EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVERNMENT RAJAJI HOSPITAL, MADURAI.

M.Sc (NURSING) DEGREE EXAMINATION

BRANCH- III OBSTETRICS AND GYNAECOLOGICAL NURSING

COLLEGE OF NURSING

MADURAI MEDICAL COLLEGE

MADURAI –625020.

A Dissertation submitted to

THE TAMILNADU DR.M.G.R. MEDICAL UNIVERSITY

CHENNAI – 600032.

In partial fulfillment of the requirement for the degree of

MASTER OF SCIENCE IN NURSING

APRIL - 2016

EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVERNMENT RAJAJI HOSPITAL, MADURAI.

Approved by the dissertation committee on 13.11.2014

Expert in Nursing Research ……

Mrs.S. POONGUZHALI, M.Sc. (N)., M.A, M.B.A., Ph.D.,

Principal,
College of Nursing,
Madurai Medical College,
Madurai-625020

Expert in clinical Specialty …….

Mrs. S.AUYISHA SITHIK M.Sc.(N)., M.B.A.(HR).,

Nursing Tutor Grade II
Department of Obstetrics and Gynaecology,
College of Nursing,
Madurai Medical College,
Madurai-625020

Medical Expert……
Prof.Dr.T.UMA DEVI, M.D., DGO.,

Professor and Head of the Department
Department of Obstetrics and Gynaecology,
Government Rajaji Hospital
Madurai-625020

A Dissertation submitted to

THE TAMILNADU DR.M.G.R. MEDICAL UNIVERSITY

CHENNAI – 600032.

In partial fulfillment of requirement for the degree of

MASTER OF SCIENCE IN NURSING

APRIL - 2016

CERTIFICATE

This is to certify that this dissertation titled**, "EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVERNMENT RAJAJI HOSPITAL, MADURAI"** is a bonafide work done by **Mrs.VANITHA.V, M.Sc(N)** student, College of Nursing, Madurai Medical College, Madurai - 20, submitted to THE TAMILNADU DR.M.G.R. MEDICAL UNIVERSITY, CHENNAI in partial fulfillment of the university rules and regulations towards the award of the degree of **MASTER OF SCIENCE IN NURSING, Branch III, Obstetrics and Gynaecological Nursing,** under our guidance and supervision during the academic period from 2014 – 2016.

Mrs. S.POONGUZHALI, M.Sc.(N)., M.A., MBA., Ph.D.,
PRINCIPAL
College of Nursing,
Madurai Medical College,
Madurai- 625020.

Dr.M.R.VAIRAMUTHU RAJU, M.D.(GM).,
DEAN
Madurai Medical College,
Madurai- 625020.

CERTIFICATE

This is to certify that this dissertation titled, **"EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVERNMENT RAJAJI HOSPITAL, MADURAI"** is a bonafide work done by **Mrs.VANITHA.V, M.Sc(N)** Student, College of Nursing, Madurai Medical College, Madurai-20, in partial fulfillment of the university rules and regulations for the award of the degree of **MASTER OF SCIENCE IN NURSING, Branch III, Obstetrics and Gynaecological Nursing** under our guidance and supervision during the academic year from 2014-2016.

Name and Signature of the Guide _____

Mrs. S.AUYISHA SITHIK M.Sc.(N)., M.B.A.(HR).,
Nursing Tutor Grade II,
Department of Obstetrics and Gynaecological Nursing,
College of Nursing,
Madurai Medical College,
Madurai-625020.

Name and Signature of the Head of the Department _____

Mrs.S.POONGUZHALI, M.Sc.(N)., M.A., M.B.A., Ph.D.,
Principal,
College of Nursing,
Madurai Medical College,
Madurai-625020.

Name and Signature of the Dean _____

Dr.M.R.VAIRAMUTHU RAJU, M.D.,(GM).,
Dean,
Madurai Medical College,
Madurai-625020.

ACKNOWLEDGEMENT

"Acknowledge him in all your ways and he shall direct your paths"

I consider it as a privilege to express my gratitude and respect to all those who guided and inspired me in the completion of this thesis. The satisfaction and pleasure that accompany the successful completion of any task would be incomplete without mentioning the people who made it possible. Whose constant guidance and encouragement rewards any effort with success

.

I praise the **LORD JESUS** who has been my source of strength in every step of my life and for his enriched blessings, abundant grace and mercy, who flourished the deserted part with rivers of blessings and enlightened my darkness by His marvelous light.

I would like to express my sincere gratitude to **Dr.M.R.Vairamuthu raju, M.D.(GM)., Dean, Madurai Medical College, Madurai** who has been challenging personality and motivating factor and for granting me permission to conduct the study in this esteemed institution.

I extend my heart felt and faithful thanks to our beloved principal and Research Guide **Mrs.S.Poonguzhali,M.Sc.(N).,M.A.,M.B.A.,Ph.D.,** Principal, College of Nursing, Madurai Medical College, Madurai for her effort less hard work, interest and sincerity to mould this study in a successful way and has given her inspiration, encouragement and laid strong foundation in research. It is very essential to mention that her wisdom and helping tendency has made my research a lively and everlasting one.

I would like to express my whole hearted thanks to **Ms.P.Malliga, M.Sc(N).,M.A(soc),** Faculty in Nursing, college of Nursing, Madurai Medical College, Madurai for her words of appreciation, unwavering encouragement, affectionate enduring support, timely correction and guidance that she has bestowed on me.

I also express my sincere gratitude to **Mrs.S.Auyisha Sithik, M.Sc(N).,M.B.A (HR)** Faculty in Nursing, College of Nursing, Madurai Medical College, Madurai -20 for her elegant direction and corrections made on my study which helped me a lot to come up to this stage. I thank her for her full support which kinded my spirit and enthusiasm to go ahead and accomplish this study successfully.

I wish to thank **All Faculties of College of Nursing,** Madurai Medical College, Madurai for their guidance and support for the completion of my study.

I also extend my sincere thanks to **Prof.Dr.T.Uma Devi, M.D,DGO, Head of the department, Department of Obstetrics and Gynaecology, Government Rajaji Hospital, Madurai** for giving permission and also for her valuable suggestions and guidance to complete this study.

My sincere thanks to **Dr.C.Shanthi, M.D, DGO, Professor, Department of Obstetrics and Gynaecology, Government Rajaji Hospital & Madurai Medical College, Madurai**. for rendering her greatest help in sharing her valuable thoughts and guiding me for the completion of the study.

I also extend my thanks to **Mrs.P.Shanthi M.Sc(N), Professor in OBG Nursing,** CSI Jeyaraj Annpackiam College of Nursing, Pasumalai, Madurai for validated the tool for this study.

I extend my thanks to **Mrs.S.Jeyasankari M.Sc(N) Associate Professor in OBG Nursing,** PIMS, College of Nursing, Pondichery, for validated the tool for this study.

I extend my thanks to **Mrs.C.Radha, M.Sc(N) Associate Professor in OBG Nursing,** Sacred Heart College of Nursing, Pudukottai, for validated the tool for this study.

I wish to extend my sincere thanks to **Statistician,** for extending necessary guidance for statistical analysis.

I am much thankful for **Mrs.Anandhi**, Valliammal Institute for her expert training provided to me in the field of Music therapy.

I also thank**, Dr.C.Raju,M.A.,Ph.D**., English Literature, an **Mrs.A.Kalavathy M.A.,** Tamil Literature for her help in editing the Manuscript.

I express my thanks to **Mr.S.Kalaiselven**, **M.A, B.LIS Librarian,** College of Nursing, Madurai Medical College, Madurai, for his help in utilizing the library facility**.**

I express my sincere gratitude to **Mr. R. Rajkumar B.Com**, Sai graphics for typing, computing and helping in making this manuscript.

I am thankful to **Mr. Samsutheen, City Xerox** and Laser point for printing and binding my entire dissertation book in time.

I thankful to my beloved colleagues **Mrs.S.Kanis rexcilin frida, Mrs.N.Sangeetha, Ms.A.Ajitha Rani and Mrs.P.Velammal** who are always be with my side for the past two years and helped me a lot in this study and all my

classmates who provided encouragement, who listened to, and always supported me during the study.

Above all I express my heartful thanks to my lovable parents **Mr.P.Velu, Mrs.Kavitha,** and my husband **Mr.N.V.Ramkumar doss,** my brother in law **Mr.Muthupandian** and my sister **V.Sangeetha,** who have been a source of strength, inspiration, constant help, encouragement, psychological and economical support to complete this research project.

My special gratitude to all my Study Subjects whose kind cooperation in this study.

Above all the investigator owes her success to **God Almighty**.

ABSTRACT

Title: Effectiveness of music therapy on postpartum blues among primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai. **Objectives:** To assess the level of postpartum blues score among primi postnatal mothers in postnatal ward. To evaluate the effectiveness of music therapy on postpartum blues score among primi postnatal mothers in postnatal ward. To associate the level of the postpartum blues score among primi postnatal mothers with their selected demographic and obstetric variables. **Hypotheses:** There is a significant difference between postpartum blues score among primi postnatal mothers in experimental and control group in postnatal ward. There is a significant association between the level of postpartum blues among postnatal mothers with their selected socio demographic and obstetric variables in postnatal ward at Government Rajaji Hospital, Madurai. **Conceptual frame work:** Modified Ernestine Widenbech's model of midwifery practice. **Methodology:** True Experimental Post test only design was used.60 mothers were selected through Simple random sampling technique by using Flip the coin method from postnatal ward in Government Rajaji Hospital, Madurai. **Findings:** Music therapy reduced the level of postpartum blues in primi postnatal mother. There was a significant association between post test level of postpartum blues and age in years, weeks of gestation, stressful events during pregnancy, obstetric outcome among primi postnatal mothers.post test showed statistically highly significant at $P<0.001$ level. **Conclusion:** This study concluded that music therapy is cost effective, non invasive, non pharmacological complementary and alternative therapy to reduce the level of postpartum blues among primi postnatal mother.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

INTRODUCTION

CHAPTER-I

INTRODUCTION

" A mother is she who can take the place of all others but whose place no one else can take."

- By Cardinal Mermillod

"Drag your thoughts away from your troubles. By the ears by the heels, or any other wall you can manage it."

- Mark Twain

Pregnancy is a unique, exciting and often joyous time in a woman's life, as it highlights the woman's amazing creative and nurturing powers while providing a bridge to the future. Pregnancy comes with some cost, however, for a pregnant woman needs also to be a responsible woman so as to best support the health of her future child. The growing fetus depends entirely on its mother's healthy body for all needs. Consequently, pregnant women must take steps to remain as healthy and well nourished as they possibly can.

Labour and childbirth are profound and unique experiences, and at the same time complex physiological processes. The desire for labour to culminate in the birth of a healthy child, with no harm to the mother's health, has led to childbirth being institutionalized and systematically managed medically, and surgical interventions being carried out without sufficient evidence of their safety and efficacy. Thus, in recent decades there has been rapid expansion in the development and use of a range of practices intended to initiate, increase, accelerate, regulate or monitor the birth process, with the aim of improving the outcome for women and their children. These have become usual, routine practices, even in births for healthy women with no

complications.This wish to guarantee the best outcomes has made it difficult to pay the necessary attention to the importance of the process of childbirth in a woman's life, emotional well-being and adaptation to motherhood, and to establishing a connection with her child, successful breastfeeding, parenting style and the later development of the children.

The birth of a child is generally viewed as a time for rejoicing, despite the physical pain and exhaustion experienced by many woman during child birth. However, for some women the experience can be a traumatic event for a variety of reasons. These include the new demands a baby can bring, anxiety is about parenting abilities, the responsibility of looking after the baby, and a host of more complex psychological, sociological, and biological matters that arise during these time of change (Currid, 2002). When these issues are not resolved positively, women may experience further difficulties in copying or crises leading to periods of mental illness, ranging from mild to severe.

Becoming a mother has been described as one of the most significant developmental tasks of adulthood (Dion, 1985).The birth of a woman's first baby is a major life event that marks the beginning of a period of cognitive transition for women– a time when women's roles and self-identities become subject to redefinition and reorganization.

New motherhood requires women to adjust to a multitude of new responsibilities and demands, for which they may have inadequate preparation and inadequate support and for which their usual organizational skills may not apply. Although new motherhood can be a joyous and meaningful experience, it holds the potential to be a stressful life event . The relentless tasks involved with infant care can

result in women experiencing losses of control and order over their routines, and in feelings of being ‘out of control’ in their lives.

Postnatal (Latin for after birth,from post-meaning after, and natalis - meaning of birth) is the period beginning immediately after the birth of a child and extending for about six weeks.Less frequently used are the terms puerperium or puerperal period. Postpartum period is associated with in-tense physical and emotional changes leading to anxiety and mood disturbances.

The World Health Organization (WHO) describes the postnatal period as the most critical and yet the most neglected phase in the lives of mothers and babies; most deaths occur during the postnatal period. It is the time after birth, a time in which the mother's body, including hormone levels and uterus size returns to a non-pregnant state. Lochia is a postpartum vaginal discharge, it containing blood, mucus, and uterine tissue.

Postnatal period is a natural condition with six transformative weeks full of excitement, planning at the unfolding of life. Every women wants to enjoy with the baby, the joy full experience of the postnatal period but not always joy full in this period, sometimes it is associated with the minor problems. It is one of the vital events, which needs special care to the postnatal period. The postnatal period represent a challenging mix of potentials. There are positive cardiovascular changes associated with pregnancies that continue for sometime following childbirth providing the mother with survival enhancement during this period however motherhood also produces greater barrier to emotional status.

Pregnancy and the postpartum period are the most dynamic events in a woman's life cycle and affect both her body and mind. After giving birth, women are required to adapt to a new role as mothers, resulting in changes in their relationships with their husband and family members, as well as family in functions. The first month after delivery is the most critical time for mothers with psychiatric symptoms, as this period is associated with a three fold increased risk of depression.

Postpartum period should be considered as a vulnerable time for the development of emotional and psychological disorders .The last part of pregnancy and childbirth can be troublesome; the body goes through rapid changes, especially hormonal. In the first day of post-partum, the body often feels painful and uncomfortable.

"PostPartum blues" is characterized by transient mood swings to a low mood 'Postpartum blues' is a mild and transient phenomenon that occurs during the first day of puerperium. The fact that a number of studies from different countries have reported a variety of prevalence rates and socio-economic factors related to the occurrence of postpartum blues has raised the issue of cultural differences and especially the influence of culture in family support during puerperium.

Postpartum blues is a transient affective syndrome, Postpartum blues are extremely common, with upto every postnatal mothers experiencing transient emotional lability in the first week of post-delivery. Postpartum blues are characterized by mild dysphoria, tearfulness, irritability and anxiety, crying, grief, sadness, confusion, headache, mood swings, fatigue, insomnia, negative thinking, low mood, difficulty in thinking and also exuberance. These symptoms tends to peak at three to five days of post-delivery and can continue for ten to fourteen

days,Postpartum blues is considered as a risk factor for postpartum depression (Henshaw et al., 2004; Bloch et al., 2005). In the etiology of postpartum blues much attention has been given to the effects of the postpartum drop of estrogen and progesterone on neurophysiology and behavior.

The Causes of postpartum blues is after the placenta is delivered the placental "hormone factors" shuts down causing radical changes in hormone levels and the woman can suffer due to withdrawal from the high pregnancy levels of estrogen, progesterone and endorphins combined with shift in hormone levels is the physical, mental and emotional exhaustion as well as sleep deprivation may also be associated with thyroid dysfunction. An association with serotonin has been suggested. All of these factors contribute to the condition.

Postpartum blue symptoms continue for longer than a period of two weeks, further assessment is required. Postpartum blues are unrelated to psychiatric history, environmental stressors, parity, or cultural context that the greater the change between pregnancy and postnatal levels of oestrogens and progesterone, the greater the likelihood of developing postpartum blues. Other authors have reported an association between dramatic hormonal changes in the immediate postpartum period and postpartum blues.

Music is one of the few things in life that has the power to move us emotionally. A piece of music can bring back memories, lifts our spirits and soothe our soul-helping us to express emotions when words fail us. It is this power that music therapy harnesses, using the various musical components to provide a way of relating within a therapeutic relationship.

Music stimulates release of endorphins and reduces need for analgesic drugs. It distracts the perception of pain and relieves anxiety and depression. Music has played an important role in different cultures. Since the time of immemorial. It has profoundly affected human being in the physical, mental, emotional and spiritual wellbeing. The sight covers the important of music in prenatal, birthing time and postnatal period (cooper,1999). When client listens to the rhythmic music the muscle movement become synchronized with the beat music induces the sedative relaxing response if it has a slow steady rhythm. Music therapy can also distract the patient from negative thought, feelings and experiences. Music therapy has been effective at helping keep peoples mind from dwelling on the pain of surgery, labour or outcome of an invasive procedure.

Music therapy is defined further as "an interpersonal process in which the therapist uses music and all of its facets – physical, emotional, mental, social aesthetic and spiritual to help patients to improve, restore or maintain health".

Music therapy is a type of creative therapy that involves listening and playing music. Depending on the needs of the participants, music therapy can foster self-awareness, communication skills and self-esteem. The therapy utilizes the social and communicative nature of music to do this and aims to facilitates positive changes in behaviour. Music therapy can help a range of people including those with emotional difficulties and those with physical limitations.

In the early history of nursing Florence Nightingale used music as an intervention for treating patients. Nightingale presented music as part of the healing process for injured soldiers and described how music used in healing could benefit the injured soldiers' health (McCaffrey &Locsin, 2002).

Music therapy has been found to have numerous significant outcomes for patients with major depressive disorder. A systematic review of five randomized trials found that people with depression generally accepted music therapy and was found to produce improvements in mood when compared to standard therapy.

The use of music as therapy has been taking place for centuries, with ancient Greece leading the way. For example, Apollo says the greek god of music and medicine proving that have been linked since at least the ancient greek era. Music therapy was even practice in biblical times, when it was thought that the David played the harp to rid kind soul of an evil spirit. Music therapy as we know today began in the wake of world wars I and II. It was then that musicians (particularly in the U.K) would travel to hospitals to play music for soldiers experiencing emotional and physical trauma. French cellist Juliette Alvin pioneered clinical musical therapy in Brittan in the 60s, and is still considered the therapy strongest influencer. Today music therapy is one of the country's leading creative therapies and is supported by the health and care professions council(HCPC).

Music therapist will use the variety of technique depending on the needs of the people taking part. That are singing, playing instruments, rhythmic based activities, improvisation, composing and song writing and listening.

Mozart is a one type of music,the soothing power of music is well-established. This type of music can have a beneficial effect on our physiological functions, slowing the pulse and heart rate, lowering blood pressure, and decreasing the levels of stress hormones. It has a unique link to our emotions, so can be an extremely effective stress management tool.

Music therapy gaining importance in complimentary and alternative medicine. Music therapy is one of the non-pharmacological interventions which involves the musical activity in the treatment of somatic and mental disorders. It helps to improve the comfort level and enhances the feeling of wellbeing by keeping them engaged by affective, cognitive and sensory mechanism. Most people tend to experience a visceral reaction to music, a burst of energy upon hearing and upbeat song or a sense of harm during a soothing classical beats. There is a connection between music and moods. Moreover scientific shows that music can affect physiological functions such as respiration, heartrate and blood pressure as well. Music has also been shown to lower amount of cortisol which become elevated under stress and anxiety. Music also increases the release the endorphins the body's natural "feel-good" hormones.

Although using music for therapy is far from standard practice in much of modern medicine, it has been accepted for decades with the first academic program to train music therapists established in 1944 at Michigan State University. But music therapy gaining traction as research continues to show its value for everything from weight loss to psychological disorders, to cancer.

Music therapy can also helps autistic children develop communication skills, help patients with Parkinson's improve motor functions, and even serve as a natural pain reliever, according to the American Music Therapy Association, which represents over 5,000 music therapists.

It can also help premature infants improve sleep patterns and gain weight. Jayne Stanley, a professor of music with a courtesy appointment in the college of medicine at Florida State University, found in her research that if premature babies were given a device that played lullabies triggered by their sucking, they left the

Intensive care unit 11 days earlier on average compared to premature babies who did not have access to music.

According to the National Institutes of Health, music can assist with various kinds of recovery and is a "low-cost intervention that often reduces surgical, procedural, acute, and chronic pain."A report published in the Journal of Music Therapy in 1993 said that listening to music can also decrease cortisol, a hormone that in high levels causes the body to build up belly fat.Music therapy treatments range from listening to music, to singing and songwriting, and even moving to music, depending on what an individual needs.

Music therapy interventions are diverse however, can be categorized as 'active', where people re-create, improvise or compose music, and 'receptive', or passive, in which they merely listen to music (Maratos, Gold, Wang, & Crawford, 2008). Receptive music therapy is more likely to be influenced by cognitive-behavioural or humanistic traditions (Maratos, et al., 2008) and may involve performance of an additional activity while listening to live or recorded music such as relaxation.

Other studies have provided insight into the physiological interactions between music therapy and depression. Music has been shown to decrease significantly the levels of the stress hormonecortisol, leading to improved affect, mood and cognitive functioning. A study also found that music led to a shift in frontal lobe activity (as measured by Electro encephalogram) in depressed adolescents. Music was shown to shift activity from the right frontal lobe to the left, a phenomenon associated with positive affect and mood.

Postpartum blues are usually brief and donot necessitate treatment beyond reassurance and support, however a proportion of women with postpartum blues will develop Postpartum depression.Mental health disorder have implications for the mother the newborn and the entire family, such conditions can interfere with attachment and some may threaten the safety and well being of the mother newborn and other children.

The cause of Postpartum blues may be biologic, psychologic, situational or multifactorial. It affects 23% of women worldwide. In a comprehensive review of literature, (bina2008) found that cultural practices could positively or negatively affect the development of Postpartum blues. A personal history or a family history of mood disorders, mood and anxiety symptoms in the antepartum as well as postpartum blues also increases the rise of postpartum depression.(APA, 200,Milgron et.al 2008) published on integrative review of 141 studies of what researchers internationally have contributed to the state of science of postpartum blues.

1.1 Need for the study

"Music is therapy. Music moves people. It connects people in ways that no other medium can. It pulls heart strings. It acts as medicine."

- Macklemore.

Postpartum blues, postpartum depression and postpartum psychosis are the three mood disturbances which are noted after delivery.Estimates all the postpartum women will experience postpartum blues and there is a period of heightened reactivity that may last up to two weeks after delivery. Postpartum depression is an intense and pervasive sadness with severe and liable mood swings and is more serious and persistent than postpartum blues. Intense fear, anger, anxiety and dependency that

persists the baby's. first few weeks are not a normal part of postnatal blues occurring of new mothers, these symptoms rarely disappear without outside help.

Postpartum depression has been classified by the diagnostic statistical manual –lV American psychiatric association 2012,one out of eight postnatal women may experience postpartum blues and it develop postpartum depression in their lifetime. It affects 11.5 million people every year,and approximately 15% of patients commit suicide.

Approximately 50% of these mothers do not seek help from any source(dennis&chung-lee 2006). The occurrence of postpartum blues among teenage mother is approximately 50% more than older mother(driscolli, 2006). Young mothers(younger than 20 years) and those with a high school education or less are likely to seek help and have higher rate of postpartum blues than other women(may berry, hoowifz&decfercq 2007)

Women who have experience high level of postpartum blue are at increased risk for postpartum depression. A prospective controlled study was conducted to investigate severe blues increases the risk of postpartum depression for the period of six months in 206 primi mothers, postpartum blues status was defined using the postpartum blues questionnaires and depression by Edinburg postnatal Depression scale, backward stepwise Cox regression analysis found severe postpartum blues and past history of depression to be independent predictors each raising the risk by all most 3times depression in those with severe blues onset sooner after delivery and lasted longer, the difference was largely accounted for by major depression, severe postpartum blues are identified risk for postpartum depression.

Depression has been related to poor mother - infant interaction and attachment difficulties furthermore, there is considerable evidence of the deleterious effect of material depression on an infant's functioning including the domains of cognition, social functioning and development milestones.

'Post-partum blues' or 'baby blues', are transitory mood changes that may begin within the first few days after delivery and last from 1 day through the first 10 days postpartum or longer. Questions have been raised about the cross-cultural validity of this phenomenon but a study of 502 postpartum women with normal delivery in Nigeria revealed a rate of 31.3%, with the predictors of post-partum blues being significant mood changes in pregnancy, admission during the pregnancy, female baby and single motherhood. Also, postpartum blues and mood changes in the early postnatal period have been found to be strong predictors of postnatal depression in Nigerian women (Adewuya, 2006).

A study to investigate serum allopregnanolone and progesterone levels in maternity blues. Fourtyprimiparas ,who delivered healthy neonates, in them blood samples were drawn an postpartum days3 of measurement of serum allopregnanolone, progesterone ,cortisol, prolactin and estradiol and every women was interviewed using stein questionnaire.The study concluded that serum allopregnanolone levels will significantly lower in women those who are experiencing postpartum Blues with respect to controlled group.

Post-partum blues usually present during the first few days postpartum, particularly in the third to fourth day, and the symptoms include tearfulness, irritability, sleeplessness and impairment of concentration. Half to two thirds of women who deliver a normal child experience such brief episodes. There is evidence

that primiparas experiencing more severe post-partum blues are at increased risk for postpartum depression, and evidence for an association between post-partum blues and later more prolonged postpartum depression.

As postpartum blues are so commonplace and considered relatively benign, the condition is often dismissed as trivial, both by lay people and healthcare professionals a natural response to massive fluctuations in hormonal levels associated with pregnancy, childbirth and the onset of lactation. However, dismissing postpartum blues as the natural sequelae of childbirth potentially negates women's distress and also fails to optimise opportunities to identify women at risk of more serious postnatal mental illnesses.There is evidence that primiparas experiencing more severe postpartum blues are at increased risk for postpartum depression and evidence for an association between postpartum blues and later more prolonged postpartum depression.

Postpartum mental illness can affect both mothers and fathers, and is not uncommon Early detection and adequate treatment is required. Every postpartum women will experience the "blues" for a few days. Between 7% and 17% may experience clinical depression, with a higher risk among those women with a history of clinical depression. Rarely, in 1 in 1,000 cases, women experience a psychotic episode, again with a higher risk among those women with pre-existing mental illness. Despite the widespread myth of hormonal involvement, repeated studies have not linked hormonal changes with postpartum psychological symptoms. Rather, these are symptoms of a pre-existing mental illness, exacerbated by fatigue, changes in schedule and other common parenting stressors.

Postpartum psychosis (also known as puerperal psychosis) is a more severe form of mental illness than postpartum depression, with an incidence of approximately 0.2%. Many women get the "Postpatum blues" during the first few days after childbirth. If you have the blues for more than a few days, or if have thoughts of hurting self or baby, This needs to be treated. Support groups and counseling and diversional therapy can help. Sometimes medicine also can help.

Music as Medicine, music can be used to relieve pain in patients. For example, surgery patients at the Cleveland Clinic that listened to recorded music saw a decrease in post-surgical pain. Music has also been shown to reduce the amount of anesthesia needed during operations. Music can be used to relieve stress and anxiety. Calming music decreases blood pressure, steadies the heart rate, and eases stress. Research has shown that music can reduce stress for patients undergoing surgeries and colonoscopies, for children undergoing medical procedures, and for patients with coronary heart disease. There is also preliminary evidence showing that listening to music can boost immune system function by decreasing stress hormones and increasing growth hormones. These changes should prime the body to be in a better state for recovering from and resisting illnesses, but the research is weak thus far and needs further investigation.

There are a range of studies that link music to happiness and pleasure in different ways. Despite the differences in the individual studies, the scientific consensus on the topic is that music does stimulate the same areas of the brain that trigger pleasure in other activities. A range of studies have found that listening to pleasurable music stimulates the mesocorticolimbic system in the brain, which is the same “pleasure center” that is triggered by humor, tasty food, and even cocaine. In

this way, you could say that music is like a drug. If music makes you happy, then it might be possible that it is good for your health.

Postpartum blues, if left unnoticed and unmanaged leads to depression or puerperal psychosis. Hence the insight of researcher felt to assess the effectiveness of Music therapy on postpartum blues among postnatal mothers. Management of postpartum blues effectively by giving music therapy to postpartum mothers.

The first month after delivery is the most critical time for mothers with psychiatric symptoms, as this period is associated with a three-fold increased risk of depression. All new mothers suffer from postpartum blues which rarely requires medication and normally resolve with support and education.This motivates the researcher to do this study.

After reviewing many literatures, based on the above statistics and the experience of the investigator during her clinical postings found that the prevalence rate of maternity blues among primi postpartum women was high. Hence the investigator is interested to conduct the study on effectiveness of music therapy on postpartum Blues, thereby to reduce their postpartum blue symptoms.

1.2 Statement of the problem

"A study to evaluate the effectiveness of music therapy on postpartum blues among primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai."

1.3 Objectives of the study

- To assess the level of postpartum blues scoreamong primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai.
- To evaluate the effectiveness of music therapy on postpartum blues scoreamong primipostnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai.
- To associate the level of the postpartum blues score among primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai.with their selected socio demographic and obstetric variables.

1.4 Hypotheses

- **H_1**– There is a significant difference between postpartum blues score among primi postnatal mothers in experimental and control group in postnatal ward at Government Rajaji Hospital, Madurai.
- **H_2** – There is a significant association between the level of postpartum blues score among postnatal motherswith their selectedsocio demographic and obstetric variables in postnatal ward at Government Rajaji Hospital, Madurai.

1.5 Operational definition

Effectiveness

In this study effectiveness refers to the outcome of the coping measures in reduction of postpartum blues symptoms measured by Am I Blue? questionnaire.

Music therapy

In this study Music therapy is a type of recreation therapy that involves listening andplaying music depending on the needs of the participant and aims to

facilitate positive changes in behavior playing the music (Mozart) through audioplayer with head set to the postnatal mother who is having postnatal blues for15minutes two times a day for 5 consecutive days.

Postpartum blues

In this study it refers to primi postnatal mothers who is having the symptoms of postpartum blues which include tearfulness, sad mood, anxiety, restlessness, agitation, and impaired concentration, impaired decision making. This symptoms are assessed by using Am I Blue? Standardized questionnaire.

Primi post natal mothers

In this study Primi postnatal mothers refers to one who has given birth for the first time by vaginal delivery, admitted in the postnatal ward at Government Rajaji Hospital Madurai.

1.6 Assumption

- Primi postnatal mothers may have varying level of postpartum blues which will interfere with their normal activities of daily living.

1.7 Delimitation

- The study is limited to 60 samples.
- The study period is limited to 4-6 weeks of data collection.
- The study is limited to primi postnatal mothers who are admitted at Government Rajaji Hospital, Madurai.

1.8 Projected outcome

Music therapy will reduce the symptoms of postpartum blues among primi postnatal mothers. It is cost effective, noninvasive and non pharmacological complimentary therapy, Which can be used as a effective intervention to reduce postpartum blues score.

REVIEW OF LITERATURE

CHAPTER-II

REVIEW OF LITERATURE

A literature review is a body of text that aims to review the critical points of current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic. Literature reviews are secondary sources, and as such, do not report any new or original experimental work. Also, a literature review can be interpreted as a review of an abstract accomplishment.

Literature review serves a number of important functions in research process. It helps the researcher to generate ideas or to focus on a research approach, methodology, meaning tools and even type of statistical analysis that might be productive in pursuing the research problem. Review of literature in the study is organized under the following headings.

This chapter deals with two parts,

Part-I : Review of literature related to studies

Part II : Conceptual framework

Part-I

The related literature is organized and presented under the following headings.

Section : I Literature related to postpartum blues among postnatal mothers.

Section : II Literature related to music therapy and its effectiveness.

Section : III Literature related to effectiveness of music therapy on postpartum Blues among postnatal mothers.

2.1 Section I:Literature related to postpartum blues among postnatal mothers.

Koji tamakoshi,(2013)conducted a study to postpartum blues and postpartum depression. This study aimed to determine the demographic and obstetric factors,

various feelings during pregnancy, and psychological factors by using the Maternity Blues Scale The answers “Having a friend I can talk to about maternity life or child rearing” a Japanese traditional support system wherein a postnatal woman lives with her husband/parents were significantly associated with postpartum blue scores., although the association between the partner’s age and these scores was marginally significant.

Moslemi, L.; Tadayon,(2012) conducted a study to postpartum blues. The aim of this research is determining frequency and several effective factors on maternity blues. In this study with 450 participations, Beck test and part of structured questionnaire completed in third trimester when prenatal visit and rest of it filled in first day after postpartum. Also Stein test was completed in 1,5,10 postpartum days.the prevalence of maternity blues was 55/3%. The predictor factors of maternity blue include economic status, parity, past admission in pregnancy, unwanted pregnancy, and mode of delivery, antenatal mood disorder and time of skin to skin contact. Concluded that the prevalence of maternity blues was 55/3%.There were significant relation between maternity blues and some of individual, obstetrical factors.

Srivalli K1, Baheshree Devi R2, Abdul Rahuman(2013) conducted a study topostpartum blues in recently delivered mothers as a cross sectional, observational study of fifty recently delivered mothers ad-mitted to the postnatal ward of Tirunelveli Medical College Hospital over a one month period, using semi structured proforma, clinical interview, checklist of common symptoms and Handley blues criteria for diagnosis of postpartum blues. The prevalence rate of postpartum blues was found to be 12% with the most common presenting symptom being insomnia, lack of energy

and dysphoric mood. Prevalence of postpartum blues in this study was similar to other data that used Handley's criteria.

Fragiskos Gonidakis *and* **Angeliki A Leonardou (2008)** conducted a study to postpartum blues and post-partum depression are twopsychological conditions that affect a large percentage of women after child delivery. Greece is a Western society that tries to retain family bonds and traditional rituals concerning birth. According to the results of studies conducted in Greece, but possibly due to different causative factors. Various clinical and biological factors were related to the occurrence of postpartum blues and post-partum depression. Stressful events and depression during pregnancy, history of depression and prolactin levels after delivery showed strong correlation with the development of post-partum depression The relation between postpartum blues and delivery through Caesarian section, as well as the role of cytokines in the development of postpartum blues are intriguing and need further investigation.

Alexandre Faisal-Cury et al, (2008) conducted a study to estimate the prevalence and track the risk factors associated with, postpartum blues . a transversal study was performed with 113 women, on the tenth day of puerperium. The instruments were used: Pitt Scale (1968), Stein (1980), Inventory for stressful life events by Holmes & Rahe (1967), and a questionnaire with sociodemographic and obstetric data. the prevalence of MB was 32.7% according to the Stein scale. In the univariated analysis, civil status and tobacco use were associated with postpartum blues. Legally married women and nonsmokers showed a risk approximately 4 times lower of experiencing the problem. postpartum blues was very prevalent in this

sample. Obstetricians must be aware of this condition which may be associated with postpartum depression.

Ruhi Khalid (2003) This study examines the prevalence of maternity blues and puerperal depression in a heterogeneous sample of 202 Pakistani women. Mothers were assessed for maternity blues two to three days after delivery. Mothers in both the groups were administered the Morsbach and Gordon's Maternity Blues Questionnaire to determine the intensity of maternity blues. The mothers in both the groups were re-examined seven to eight weeks later on Pitt's Questionnaire (1968) for puerperal depression. It was found that there was positive correlation between the scores of MBQ and the Pitt's Questionnaire for the experimental group only.

Hau Florence WL, Levy Valerie A (2003) conducted an exploratory survey on Prevalence of Maternity Blues among Hong Kong Chinese women involving a convenience sample of 88. Participants completed a blues self-rating scale every day for first seven days after delivery. Data were analyzed mainly in terms of descriptive statistics. The survey revealed that 39(44%) woman experienced an episode of the blues during the first week after delivery and the manifestations of the blues showed a typical peaking on the 5^{th} postnatal day

Florence WL Hay, Valeriea, Levy ,(2002), An exploratory study was conducted to know the prevalence of maternity blues in Hong Kong Chinese women .A prospective survey involving a convenience sample of 88 women. Executed on the first day after normal or operative vaginal delivery. Participants completed a blues self –rating scale .Every day for first 7 days after delivery. The study Results revealed that 39(44.3%) women experienced an episode of the blues during the first week after delivery .The study Concluded that Hong Kong Chinese women

experience the maternity blues in similar ways to those reported by studies of women in their countries.

Kennerly H, S Iles, D Gath,(2002) conducted a comparative study to assess Maternity Blues between Post Operative Woman and Postnatal Woman. A new scale for the detection and assessment of maternity blues was completed by 56 women daily for ten days after elective gynecological surgery. When their responses were compared with those of 87 postnatal women, they differed significantly in frequencies of different symptoms at different times. Their findings that postnatal mood changes ('Maternity Blues') are characteristics of the puerperium and not simply non-specific reactions to physical and emotional stress.

Kennerly H, S Iles, D Gath,(2000) One hundred and six women were assessed psychiatrically in the 14-16th and 36-38th weeks of pregnancy and the 12th week after childbirth. They also completed a maternity blues questionnaire daily in the ten days after delivery. Blues scores were significantly associated with: neuroticism; anxiety and depressed mood during pregnancy; fear of labour; poor social adjustment; and retrospective severity of pre-menstrual tension. Blues scores were not associated with obstetric factors, with previous history of psychiatric disorder, or with case status on the PSE in pregnancy or 12 weeks after delivery.

Kennerly H, S Iles, D Gath,(2000) Maternity Blues, although seldom a serious problem in clinical practice, is potentially important to research on affective disorders in general. Childbirth is a major life event known to be associated with large changes in maternal hormones. The determinants of the Blues may therefore be psychological and social, or biological, or both. This paper reviews the relevant literature. Reported associations between Maternity Blues and psychiatric disorder are

examined. Possible psychological, social and biochemical determinants are reviewed, but no firm inferences on causation can yet be drawn. Conflicting results in the literature may have been due to variations in definition and measurement of the syndrome. The authors have recently used psychometric methods to develop a questionnaire for detecting and measuring Maternity Blues.

2.2 Section II: Literature related to music therapy and its effectiveness

Heather E. Hooks (2014) Conducted the study was to determine whether therapeutic music affects the patient's perception of pain, postoperative day 1 after knee replacement surgery in an inpatient hospital. Sixty knee replacement patients were randomly placed in the music group or the quiet group. The Faces Pain Scale Revised with Numeric Rating Scale was used to measure pain levels. Statistical analysis between the music group and the quiet group indicated a significant difference in patient's pain levels (F = .298; p =.037). Study results support music decreasing patient's perception of pain. Nurses can suggest music intervention to decrease pain with this patient population knowing evidence based practice supports the efficiency of music.

MC.Leod.R (2012) conducted an interventional study in nine wells hospital Dundee, to assess the effectiveness of music on patient anxiety levels during minor plastic surgery. The sample size was 80, among these n=40 are in experimental group and n=40 are in control group. Eighty patients attending a minor plastic surgery outpatient department were assessed using the spielberger state trait anxiety inventory questionnaire. Forty participants in the experimental group listened to music which was self selected and played during their operation. Forty participants in the control received the standard care during their operation but with no music.

Fleoy ysmael,lagrimas elizon(2010) This study determined the effects of music on the duration of the second stage of labor among primigravida or women in their first pregnancy at Cebu City Medical Center. An experimental design was utilized in this study with experimental and control group. A random sampling was utilized.All respondents had Normal Spontaneous Vaginal Delivery (NSVD). Each qualified respondent was chosen randomly to three conditions. A total of forty-five respondents (15 for classical music group, 15 fast music group and 15 for silence or control group) was selected. The shorter the second stage of labor, the more effective is the treatment provided. Findings revealed that the group of mothers who had no music has the shortestduration of the second stage of labor, followed by the group using fast music and the longest duration was that of the group using slow music. ANOVA computation was done which was significant at p=.05. Scheffe's Test further showed that fast music is more effective in hastening the second stage of labor than slow music and a significant difference between the slow music group and the no music group was also identified.

Yang et al., 2009, The study included women with diagnosis of threatened preterm birth, at gestational ages between 28 and 36 weeks who had been hospitalized for 48 hours or more, with a single healthy fetus. Women in the intervention group were brought to a private room to receive 30 minutes of music listening a day over course of 3 consecutive days. Women in the control group were brought to a private room to receive 30 minutes of relaxation a day over course of 3 consecutive days. Music chosen for intervention group had tempos of 60 – 72 beats per minute, consisted of low to moderate pitch levels and "harmonious melody" (Yang et al., 2009 p. 319). Both groups were asked to empty their bladders before music or

relaxation intervention. “Additionally, all of the between group differences for pre- and post-intervention measures were statistically significant (p< or = 0.01)” The authors concluded that, when controlling for rest, music is still effective in reducing anxiety levels in women on bed-rest due to high risk pregnancy.

Good. M. et.al (2008) conducted a study to find the effect of music on sensation and distrust of pain in those primiparous women during the active phase of the labor. The gate control of pain was the theoretical framework for the study. Randomization with a computerized minimization program was used to assign women to a music (n=55) or a control group (n=55). Women in the intervention group listened to soft music without lyrics for 3 hours starting early in the active stage of labor. Dual visual analog scales were used to measure sensation and distress of pain before starting the study and at 3 hardly post test. Effect size 12 respectively, sensation and distress significantly increased across the 3 hours in both groups($p<0.001$), except for distress.

Rajkumari et.al(2007) conducted a study on effectiveness of music therapy in terms of level of pain perception among primi gravid mother in southern railway hospital, Chennai. Based on the non-probability purposive sampling technique, 30 mothers were allotted for experimental and 30 mothers were allotted for control group. Music therapy was given to assess the level of labor pain perception. The pre and post assessment of lavel of labor pain was obtained using a modified combined numerical categorical pain intensity scale. It reveals that the primi gravid mother’s pain perception level was reduced after music thera**py.**

Snyder. M.chlan.L. et.al (2005) conducted a study on music as therapy in unitd kingdom. It is a qualitative semi structured interview. The efficacy of music in

managing pain in decanting anxiety and aggressive behavious and in improving performance and well being have been concreted by nurses and other health professionals. This type of musical selection used, the close of the intervention number of sessions the population studied and the metrological used music was found to be effective in producing positive outcome.

Lilly podder.et.al (2005) conducted an experimental study to evaluate the effects of music therapy on anxiety level, pain perception and labour outcome in mothers during the first stage of labor in a selected hospital in kotkata. Post test control group design was selected. Out of 60 samples 30 were to experimental and 30 were control group. The tool used for the study was a structures interview schedule for demographic data, structures record analysis performa for labor assessment, state trait anxiety scale for anxiety assessment, numeric pain intensity scale for pain assessment and proforma for fetal and maternal outcome. The study reveals that those who were exposed to music therapy experienced significantly less pain and reduction in anxiety level during labor than the control group mothers.

Kathryn Blauvelt Fulton(2005) This study examined the effects of music therapy on women in early labor. Dependent variables were fetal heart rate (FHR), uterine contraction intensity (UCI), perceptual pain, and perceptual fatigue. Subjects were forty (N=40) parturients undergoing labor induction procedures. Subjects were randomly assigned to an experimental group (N=20) or control group (N=20). All subjects gave written consent prior to participation in the study. Results showed no significant differences in demographic or labor state variables between groups. ANOVA revealed self reported pain and fatigue were significantly lower for the

music group. No significant differences were found for fetal heart rate or uterine contraction intensity. Further results and implications are discussed.

Cathy H. McKinney, (2005),Music therapy has been applied in obstetrics both during pregnancy and at the time of labor and delivery. The purpose of this article is to review published and unpublished sources which document applications of music therapy both to the treatment of psychological variables during pregnancy and to the facilitation of the birthing process during labor and delivery. Although refinement of methods is needed in the selection of music and adaptation of music therapy techniques to prepared childbirth methods other than Lamaze, the existing literature base supports the potential of obstetrical music therapy to make a significant contribution to maternal and neonatal health.

Woper.et.al (2004) conducted a study to brain has an internal time keeper which makes us all sensitive to rhythm. When music is played, our brains time to the rhythm and follow it. We get a real sense of wellbeing and relaxation and tests on bed bound patients. They have shown reduction in blood pressure and stress. The music stimulates the release of endorphins and reduces the need for analgesic drugs. It distracts from the perception of pain and relieves anxiety and depression.

Pelletier, C.L.(2004). The effect of music on decreasing arousal due to stress: A meta-analysis. A meta-analytic review of research articles using music to decrease arousal due to stress was conducted on 22 quantitative studies. Results demonstrated that music alone and music assisted relaxation techniques significantly decreased arousal (d = +.67). Further analysis of each study revealed that the amount of stress reduction was significantly different when considering age, type of stress, music

assisted relaxation technique, musical preference, previous music experience, and type of intervention. Implications and suggestions for future research are discussed.

Bittman *et al* (2000) examined the impact of a music therapy intervention on occupational stress. It found that a six week, in-house recreational music-making programme significantly improved the morale of stressed workers at a care facility for elderly people. The authors noted that an economic impact model developed by independent consultants estimated that the increased staff satisfaction created by the programme could potentially cut employee turnover by 18.3% annually.

2.3 Section III: Literature related to effectiveness of music therapy on postpartum blues among postnatal mothers

Angel Rajakumari,G. Sheela,R. (2013) The study was conducted in Vijayalakshmi Hospital, in suryapet in with 700 annual births. The postnatal mothers were recruited and were allocated by non-probability purposive sampling technique into the two arms of the study, but only 30 in study and 30 in control group participants. music was given by investigator for 20 minutes again the same step is repeated in a 10 minutes interval. Before starting the intervention, pre assessment level of depression was done in both experiment and control group. Post test was assessed without administering the music for the control group. In the experimental group, the investigator assessed the level of depression by using modified Beck's depression Scale. The postnatal mothers completed the demographic and obstetrical information and postnatal depression was measured by The Beck's Depression scale Inventory to measure presence and degree of depression in postnatal mothers. This study revealed that there was high significant difference found in postnatal depression at $p<0.001$level between experimental group. The study concluded that, clinical

implementation of music therapy usage during postpartum period could be an effective non pharmacological intervention in reducing depression.

Ussell e. hilliard, (2013) This study was conducted to evaluate the Effects of Music Therapy-Based Bereavement Groups on Mood and Behavior of Grieving Children The purpose of this study was to measure the effects of music therapy-based bereavement groups on mood and behavior of grieving children. Eighteen subjects were assigned to one of two groups: experimental (8 sessions of group music therapy) or control (no group music therapy). All subjects participated in a battery of psychometric tests which measured behavior, mood, and grief symptoms for both pretests and posttests. Statistical analysis indicated a significant difference among subjects in the experimental group for the behavior Rating Index for children in the home environment and the Bereavement Questionnaire for Parents/Guardians. The investigator concluded that participation in music therapy-based bereavement groups served to reduce grief symptoms among the subjects as evaluated in the home. Further research studying the effects of music therapy on grieving children is recommended.

Angel Rajakumari.G, Sheela.R (2013) To evaluate the effectiveness of music therapy in terms of level of postnatal depression among postnatal mothers. Participants and setting: The study was conducted in Vijayalakshmi Hospital, in suryapet in with 700 annual births. The postnatal mothers were recruited and were allocated by non-probability purposive sampling technique into the two arms of the study, but only 30 in study and 30 in control group participants. Intervention: music was given by investigator for 20 minutes again the same step is repeated in a 10 minutes interval. Before starting the intervention, pre assessment level of depression was done in both experiment and control group. Post test was assessed without administering the music for the control group. In the experimental group, the investigator assessed the level of

depression by using modified Beck's depression Scale. Measurement and findings: The postnatal mothers completed the demographic and obstetrical information and postnatal depression was measured by The Beck's Depression scale Inventory to measure presence and degree of depression in postnatal mothers. This study revealed that there was high significant difference found in postnatal depression at $p<0.001$level between experimental group. Conclusion: The study concluded that, clinical implementation of music therapy usage during postpartum period could be an effective non pharmacological intervention in reducing postpartum blues.

Melissa M Terry, Daniel R Terry, (2012). Postpartum blues, is not a new condition, but has been well documented for decades, as have the treatments. The most common treatments for postpartum blues include pharmacological, psychological, psychosocial, relaxation and other holistic methods and may be used individually or in various combinations. Recently, the western world has come to acknowledge and use more traditional or complementary and alternative styles of therapy. These specifically include massage, meditation and yoga, and music therapy. Music has become more popular as more research defines its power over the body, both physically and mentally. It is anticipated with the right information any woman, no matter her location, could use this powerful tool to alleviate the symptoms of postnatal depression. This would also save further distress of separation from family and other support networks as well as reduce financial burdens when seeking care. A literature review was conducted to determine if this relatively new intervention in western society has been used and to determine what the outcomes have been. Currently, no research has been conducted which relates to the use of music as an intervention for women with postnatal depression, particularly those in rural areas.

Mrs.S.Shanmugam Rajamani (2012) was conducted the study to evaluate the effectiveness of complementary and alternative therapies in terms of postnatal blues. A quantitative study ,experimental design,60 samples, guided imagery was given by using Walkman and visual stimulation .there was no association between the postnatal blue score and type of family of the postnatal mothers in the experimental group. there was a significant negative correlation between postnatal blues and self esteem among postnatal mothers (-0.96)at0.05 level of significance

Sun mi lee (2010), Effects of Music Therapy on Postpartum Blues and Maternal Attachment of Puerperal women. The purpose of this study was to determine the effects of music therapy on postpartum blues and maternal attachment of puerperal women. The research design was a nonequivalent control group non-synchronized design. The participants were puerperal women who agreed to participate in this study and through a convenience sampling, 60 puerperal women were recruited (30 in the experimental group, 30 in the control group). music therapy was provided to the experimental group over 30 min, once a day, and for 5 days. Then, postpartum blues and maternal attachment for the experimental and control group were measured again on the 5th day. The data were analyzed using the SPSS WIN 12.0 Program**.** These findings indicate that music therapy has positive influences on decreasing postpartum blues and increasing maternal attachment of puerperal women.

PART- 2

2.4 Conceptual framework

It is interrelated concepts or abstractions assembled together in a rationale scheme by virtue of their relevance to a common theme. It is overview of entire study of the investigator.

This study is based on modified model of Ernestine Wiedenbach's helping art of clinical nursing theory by the year of 1970, which would be relevant to reduce the symptoms of post partum blue among post natal mothers. Ernestine Wiedenbach's proposed prescriptive theory of nursing which is described as a conceiving of a desired situation of the ways to attain it, prescriptive theories direct action toward an explicit goal. It consist of three factors,

- ❖ Central Purpose
- ❖ Prescription
- ❖ Realities

Central purpose

In this model central purpose refers to what the investigator wants to accomplish. It is the overall goals towards which a investigator strives it transcends the immediate intent of the assignment or task by specifically directing activities towards the mothers good. The central purpose of the study is to promote healthy mind and to reduce level of post partum blue scores. The investigator plans the prescription that will fulfill the central purpose by identifying the various mean to achieve the goal.

Prescription

Prescription refers to plan of care for a patient. Once the investigator identified needs of the patient, she develops a prescription or plan of care, in this study, the investigator planned to provide music therapy for experimental group.

Realities

Realities refer to physical, psychological, emotional and spiritual factors that affect the nursing action.

The Realities are

- **Agent :** It means who is the practicing nurse. In this study researcher is the agent.
- **Recipient :** The patients are the recipients of the nurse's action. In this study the primi postnatal mothers admitted in postnatal ward were the recipients.
- **Environment:** It means which indicates the physical environment where the postnatal mothers are admitted.

The conceptual framework of this nursing theory consists of following steps

Identifying the need for help:

In identification there are four distinct steps,

1. Observes the patient, looking for an inconsistency between the expected behavior of the patient and the apparent behavior.
2. Second attempts to clarify what inconsistency means.
3. Determines the cause of the inconsistency.

The investigator must assess or to identify the needs of the mother before going to do prescription of the intervention. The investigator used the following instruments to assess the need of the mother. Demographic variable like age, education, occupation, religion, income, type of the family, duration after marriage,

marital relationship, obstetrics variables like weeks of gestation, baby gender, stressful events during pregnancy, family support system, family history of depression, obstetric outcome. Assessment level of post-partum blue scores by using "Am I Blue?"Questionnaire.

Ministering the needed help

It refers to the agent, recipient and environment involved in nursing actions. Agent which denotes to the investigator those who are going to give prescription or intervention to the postnatal mothers. Here the investigator prescribed music therapy for the experimental group. Recipient which means those who are going to get benefits from the investigator, in this study recipient is postnatal mothers and the environment which indicates the physical environment where the postnatal mothers are admitted.

Means

In this study the investigator had means to implement the prescription experimental group selected for music therapy and control group had no intervention. Each group had 30 postnatal mothers. Experimental group underwent music therapy since 5 days twice daily.

Validating needed for help was met

After help has been ministered the nurse validates that the actions were indeed helpful. Here the investigator validates by means of post test assessment. It refers to evaluate the effectiveness of the music therapy by level of postnatal blues. "Am I blue?" questionnaire used to assess the level of postnatal blues on both the group.

Outcome

It is the effect of music therapy. It can be positive or negative outcomes. Positive outcomes have no postnatal blues and negative outcome have the postnatal blues.

RESEARCH METHODOLOGY

CHAPTER-III

RESEARCH METHODOLOGY

The methodology of research indicates the general pattern of organizing the procedure for assembling valid and reliable data for investigation. This chapter provides a brief explanation of the method adopted by the investigator in this study. It includes the research approach, research design, and variables, setting of the study, population, sample and sample size, sampling technique, description of the tool, pilot study, data collection procedure and plan for data analysis.

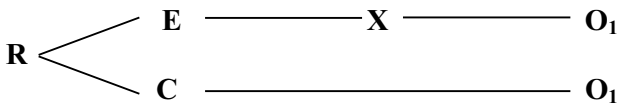
This chapter deals with the description of methodology and different steps that are taken for gathering and organizing data for the investigator to assess the effectiveness of music therapy on postpartum blues among primi postnatal mothers .

3.1 Research approach

A quantitative evaluative approach was used to test the effectiveness of intervention.

3.2 Research design

The research design used for this study is True Experimental -Post test only design was selected. A true experimental design involves Manipulation, control and Randomization.



R - Randomization.

E - Experimental group

C- Control group

X – Intervention Playing the music (Mozart) through audio player to

O_1 - Post-test for both and control by using Am I Blue? Questionnaire.

3.3 Variables

- **Independent variable**

  In the present study, the independent variable is the Music therapy.

- **Dependent variables**

  In the present study, the dependent variable is postpartum blues.

- **Socio demographic variables**

  In this study socio demographic variables are age of the mother, Education status, Occupation, Income, Religion, Type of family, Duration after marriage, Marital relationship, Type of food.

- **Obstetric variables**

  In this study obstetric variables are Weeks of gestation, Baby gender, Stressful events during pregnancy, Family Support system, Family history of depression, Obstetric outcome.

3.4 Setting of the study

The study was conducted among primi postnatal mothers who are admitted in the postnatal ward at Government Rajaji Hospital Madurai. At present there are about 2518 beds available in Multi Specialty Medical College attached Hospital and it provides a comprehensive care to all. Madurai Medical college is the second largest in Tamil Nadu. Department of obstetrics and gynaecology consists of 650 beds, the total number of deliveries per month is 1400 approximately. In which normal deliveries per day is 25 to 30 and per month is 780 deliveries.

3.5 Population

Target population

Target population of the study was all primi postnatal mother with postpartum blues.

Accessible population

Primi Postnatal mothers with postpartum blues who were admitted in postnatal ward at Government Rajaji Hospital, Madurai.

3.6 Sample

The sample of the present study was Primi postnatal mothers with postpartum blues symptoms who were admitted in postnatal ward at Government Rajaji Hospital, Madurai. and who fulfilled the inclusion criteria.

3.7 Sampling technique

Sampling Technique used in the study was Probability sampling- Simple random sampling.

3.8 Sample size

The sample size consist of 60 primi postnatal mothers (30 in experimental group and 30 in the control group) Who are admitted in the postnatal ward at Government Rajaji Hospital, Madurai.

3.9 Criteria for sample selection

Inclusion criteria

1) Primi Postnatal mothers who were willing to participate in the study.

2) Primipara mothers who had normal vaginal deliveries.

3) primipara mothers age group between 18-32yrs.

4) Mothers whose baby are in NICU.

Exclusion criteria

1) postnatal mothers those who have deaf and dumb.

2) Mothers who were having the previous medical and psychiatry illness.

3.10 Research tool and technique

The tool was developed and standardized from extensive review of literature and discussion with the experts in the field. The tool consists of two sections. They were

Section A : Socio demographic and obstetric variables.

Section B: Standardized Am I Blue ? Questionnaire.

3.10.1 Description of the tool

The tool consists of two sections.

Section A : Consists of socio demographic variables and obstetric variables like Age of the mother, Education status, Occupation, Income, Religion, Type of family, Duration after marriage, Maital relationship, Weeks of gestation, Baby gender, Stressful events during pregnancy, Family Support system, Family history of depression, Obstetric outcome

Section B : Standardized am I blue ? Questionnaires consist of 30 items such as Anger, Anxiety attacks periods of very strong fear, Increased or decreased appetite , Strong feeling that you need to get away, Problems in relationship with the family member, Crying spells, Less interest in your personnel appearance, Less motivation-less energy, Depression, Fatigue-feeling tired, Fear of harming yourself or your body, Nervousness, Feelings of guilt, Feelings of panic, Feelings alone, Feeling forgetful, Frustration, Hopelessness, Insomnia, Feeling irritable,

Loss of sexual desire, Loss of self respect or confidence, Feeling confused and uncertain, Mood swings, Obsessive thoughts-ideas, Frightening thoughts., Thoughts of suicide, Feeling sad and unhappy.

Scoring Interpretation

Section A: No scoring was allotted for the demographic and obstetric variables.

Section B: Standardized am I blue ? Questionnaire was used for assessing the level of postpartum blues .The tool consist of 30 items. The total score is 90 which were given by 0-No symptoms, score (1)-mild , score (2)-moderate, score(3)-severe

Description of scoring

SCORES	LEVEL OF BLUES
O-30	MILD BLUES
31-60	MODERATE BLUES
60-90	SEVERE BLUES

3.10.2 Testing of the tool

Validity

The content validity was obtained from three obstetrical and gynecological nursing experts and professors of obstetrical and gynecological department, psychiatry department, psychology department, clinical experts suggestions were incorporated in the tool.

Reliability

The tool reliability was assessed by test retest method correlation coefficient value(r = 0.86) the reliability test score shows there is a stability and consistency in the tool items. Hence the tool was considered highly reliable for proceeding with the main study.

3.11 Pilot study

A formal permission was obtained from institutional review board/ethical committee and, professors in obstetrical and gynecological department, Government Rajaji Hospital, Madurai. The pilot study was conducted at above department for a period of 7 days from 01/06/15 to 07/06/15. About 10 primi postnatal mothers with postnatal blues were selected as per the inclusion criteria by using simple random sampling technique. In this sample were divided into 5 in experimental group 5 in control group.

An oral and written consent was obtained from the each study samples. The mothers were explained about the purpose of the study and assured of confidentiality of the data collected. First the mothers were screened for any complications in their antenatal period. Then 10 mothers are selected (5 mothers in control group and 5 mothers in experimental group). Intervention of music therapy was given through head phone to the experimental group. The results were revealed that the outcome was good in experimental group when they were compared with control group. Hence the results of this study suggested that the study was feasible and practicable to conduct the main study.

DATA ANALYSIS

AND

INTERPRETATION

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the description of sample, analysis, and interpretation of the data collected from 60 postnatal women, to assess the Effectiveness of music therapy on postpartum blues among primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai. Analysis and interpretation of data is the important step in research process.It involves the computation of the certain measures along with searching for patterns of relationship that exists among the data groups.

4.1 Presentation of data:

The study findings of the sample are presented in the following sections.

Section I: Distribution of socio demographic variables and obstetric variables of experimental group and control group.

Section II: Description of level of postpartum blues among experimental group and control group.

Section III: Effectiveness of music therapy among experimental and control group.

Section IV: Comparison of the posttest level of postpartum blues score between experimental and control group

Section V: Association between posttest levels of postpartum blues among experimental group with their socio demographic and obstetric variables

Section – I

Table – 1 Frequency and percentage distribution of primi postnatal mothers according to their socio demographic data

n=60

Socio demographic variables	Group			
	Experimental		Control	
	f	%	f	%
1.Age in years				
18 - 22 yrs	11	36.7%	9	30.0%
23 - 27 yrs	16	53.3%	14	46.7%
28 - 32 yrs	3	10.0%	7	23.3%
2. Education				
No formal education	1	3.3%	3	10.0%
Primary education	12	40.0%	11	36.7%
Higher secondary education	13	43.4%	11	36.7%
Graduate	4	13.3%	5	16.6%
3. Occupation				
Home maker	24	80.0%	23	76.6%
Daily wages	3	10.0%	3	10.0%
Private employee	2	6.7%	2	6.7%
Government employee	1	3.3%	2	6.7%
4. Income				
Rs.3000-4000	11	36.7%	4	13.3%
Rs.4001-5000	10	33.3%	11	36.7%
Rs.5001-6000	4	13.3%	6	20.0%
Rs.>6000	5	16.7%	9	30.0%
5. Religion				
Hindu	17	56.7%	23	76.7%
Muslim	5	16.6%	4	13.3%
Christian	8	26.7%	3	10.0%

Socio demographic variables	Group			
	Experimental		Control	
	f	%	f	%
6.Type of family				
Nuclear family	13	43.4%	11	36.7%
Joint family	15	50.0%	18	60.0%
Extended family	1	3.3%	0	0.0%
Separated family	1	3.3%	1	3.3%
7.Duration after marriage				
0-1 year	26	86.7%	23	76.7%
2-5 years	4	13.3%	7	23.3%
8.Marital relationship				
Satisfied	26	86.7%	24	80.0%
Unsatisfied	4	13.3%	6	20.0%
9.Food habits				
Vegetarian	9	30.0%	6	20.0%
Non-vegetarian	21	70.0%	24	80.0%
OBSTETRIC VARIABLES				
10.Weeks of gestation				
<37 weeks	6	20.0%	5	16.7%
37-38weeks	9	30.0%	11	36.7%
39- 40 weeks	15	50.0%	14	46.7%
11.Baby gender				
Male	14	46.7%	16	53.3%
Female	16	53.3%	14	46.7%
12.Stressful events During pregnancy				
Yes	7	23.3%	6	20.0%
No	23	76.7%	24	80.0%
13.Family support				
Husband	20	66.7%	23	76.7%
Relatives	10	33.3%	7	23.3%

Socio demographic variables	Group			
	Experimental		Control	
	f	%	f	%
14. Family H/O Depression				
Yes	6	20.0%	4	13.3%
No	24	80.0%	26	86.7%
15.Obstetric outcome				
Healthy baby	14	46.7%	12	40.0%
Preterm baby	7	23.3%	8	26.7%
Low birth weight	9	30.0%	10	33.3%

The above table represents that the age limit of the mothers between 18-22yrs in experimental group were 11(36.7%) and 16(53.3%) were 23-27 yrs and 3(10%) mothers were 28-32 years. Whereas in the control group 18-22 years were 9(30%)and 23-27 years were 14(46.7%) and 7(23.3%) mothers were 28-32 years of age.

With the view of educational status, In the experimental group,1(3.3%)women were no formal education and 12(40%) mothers were finished their primary education and 13(43.4%) mothers were completed their higher secondary education and 4(13.3%) were graduate. but in the control group 3(10%) were no formal education and 11(36.7%) were primary education and 11(36.7%) were completed their higher secondary education and 5(16.6%) were graduate.

In the view of occupation, In the view of occupational status majority of the subjects in experimental group 24 (80%) were home maker and 3 (10%) were daily wages.,2(6.7%) were working as a private employee,1(3.3%) were working as government employee. In control group 23(76.6%) were home maker and 3 (10%) were daily wages.,2(6.7%) were working as a private employee,2(6.7%) were working as government employee..

Considering the monthly income majority of the subjects in experimental group majority of the subjects 11 (36.7%) were get Rs.3000 -.4000, And 10 (33.3%) were get Rs. 4001-5000, and 4(13.3%) were get Rs.5001-6000 and 5(16.7%) were get Rs.> 6000. In control group majority of the subjects 11 (36.7%) wereget Rs.4001 -.5000, and 4 (13.3%) were get Rs 3000-4000, and 6(20.0%) were get Rs. 5001-6000/-. and 9(30.0%) were get Rs.> 6000.

With regard to religion, In experimental group 17 (56.7%) belongs to Hindu religion, 5(16.6%) belongs to Muslim and 8(26.7%) were belongs to Christian. In control group 23 (76.7%) belongs to Hindu religion, 4(13.3%) belongs to Muslim and 3(10.0) belongs to Christian.

In the aspect of type of family, in experiment group 13 (43.4%) belongs to nuclear family, 15 (43.4%) belongs to joint family and 1(3.3%) were belongs to extended family, 1(3.3%) belongs to separated family. In control group 11 (36.7%) mothers were belongs to nuclear family, 18 (60%) belongs to joint family, only one (3.3%) mother were belongs to separated family.

Regarding the duration of marriage, majority of mothers in experimental group 26(86.7%) mothers were 0-1 yrs of duration and 4(13.3%) mothers were 2-5yrs of duration. In control group 23(76.7%) mothers were 0-1yrs and 7(23.3%) mothers were 2-5 years of duration.

Considering the marital relationship, majority of the subjects 26(86.7%) mothers were satisfied with their marital relationship in experimental group and 4(13.3%) mothers were unsatisfied marital relationship. In control group 4(13.3%) mothers were satisfied marital relationship and 6(20%) had unsatisfied marital relationship.

With the view of habits majority of the subjects in experimental group 9 (30%) were vegetarian, 21(70%) were non vegetarian. In control group 6 (20%) mothers were vegetarian and 24 (80%) were non vegetarian.

With the aspect of weeks of gestation in experimental group 6 (20%) mothers were < 37 weeks and 9 (30%) mothers were 37-38 weeks of gestation and 15(50%) mothers were 39-40 weeks. In control group 5(16.7%) were < 37 weeks 11(36.7%) were 37-38 weeks and 14(46.7) were 39-40 weeks of gestation.

Regarding this study in experimental group 14 (46.7%) of mothers had male baby and 16(53.3%) had female baby. In control group 16(53.3%) of mothers had male baby and 14(46.7%)) of mothers had female baby.

Comparing the stressful events of the mother's life in experimental group 7(23.3%) had stressful events during pregnancy and 23(76.7%)..In control group 6(20%) had stressful events during pregnancy, and 24(80%) had stressful events during pregnancy

In the view of family support, in experiment group 13 (43.4%) mothers were support by husband and 10(33.3%) mothers were supported by relatives. In control group 23(76.7%) mothers were support by husband and 7(23.3%) mothers had supported by relatives.

With the view of majority of the subjects in experimental group 24(80%)were no family h/o depression and 6(20%) had family h/o depression. In control group majority 26(86.7%) were no family h/o depression and 4(13.3%) had family h/o depression.

In the aspect of obstetric outcome in experimental group 14(46.7%) mothers had healthy baby and 7(23.3%)mothers had preterm baby, 9(30%) mothers had low birth weight baby. In control group 12(40%) mothers had healthy baby and 8(26.7%) mothers had preterm baby, 10(33.3%) mothers had low birth weight baby.

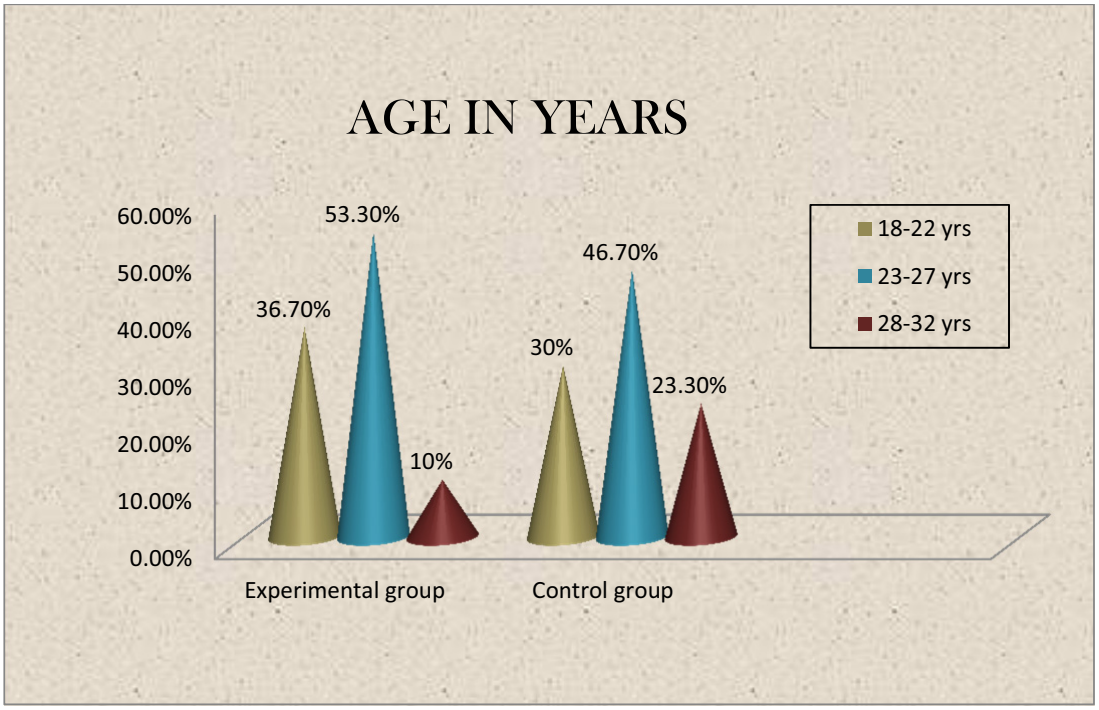


Figure 1 : Cone diagram showing percentage distribution of primi postnatal mothers in postnatal ward according to their age.

Majority of the mothers in experimental group 16(53.3%) were in the age group of 23-27 years. In the control group majority of the subjects 14(46.7%) were in the age group of 23-27 years of age.

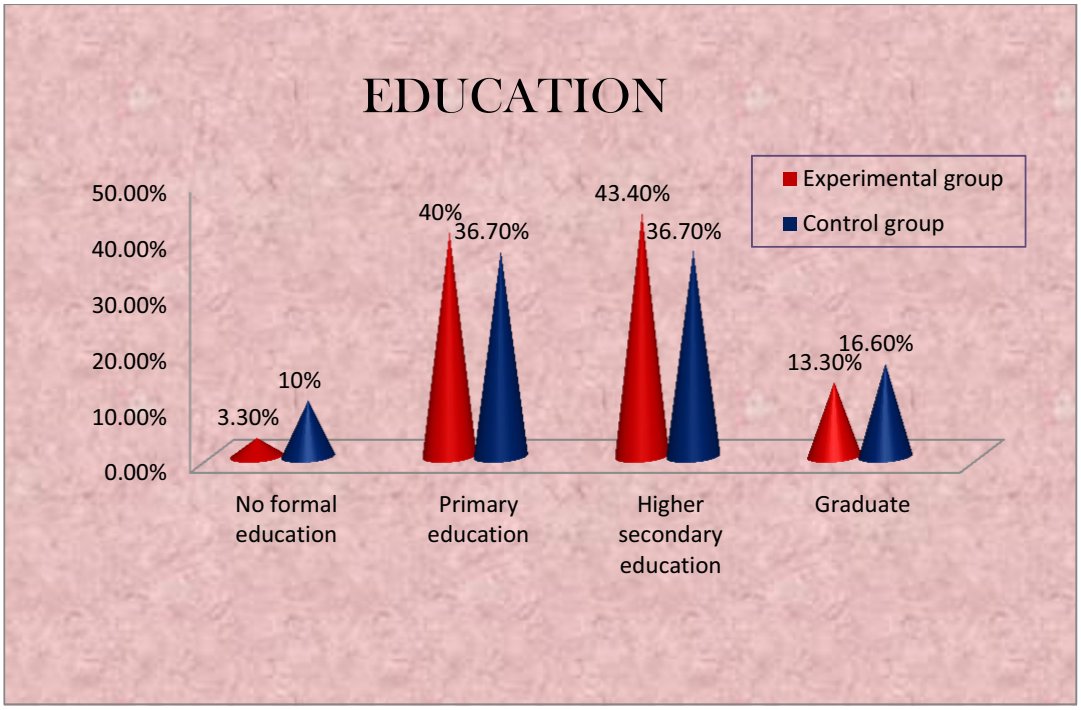


Figure 2: Multiple cone diagram showing the percentage distribution of primi postnatal mothers according to their educational status.

Majority of the mothers in experimental group 13(43.4%)of mothers have completed their higher secondary education . In the control group majority of the subjects 11(36.7%) were primary education and 11(36.7%) were completed their higher secondary education.

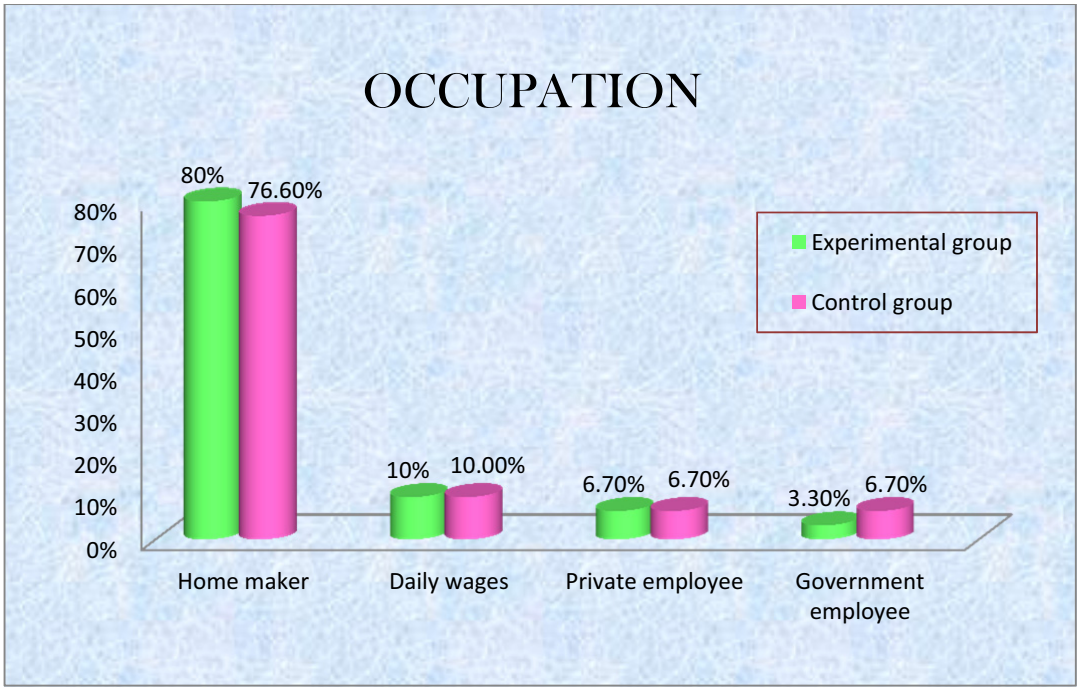


Figure 3: Multiple cylindrical diagram shows the distribution of primi mothers in according to their occupation.

In the view of occupational status majority of the subjects in experimental group 24 (80%) were home maker In control group 23(76.6%) were home maker.

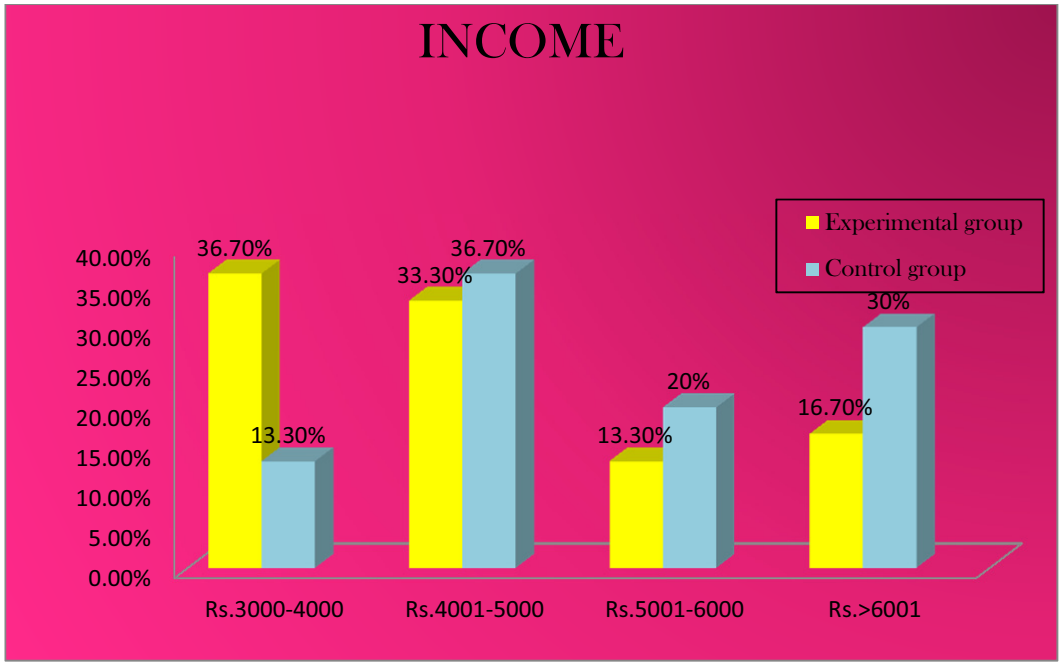


Figure 4 : Multiple bar diagram shows the distribution of primi postnatal mothers in according to their monthly income.

Considering the family monthly income majority of the subjects in experimental group majority of the subjects 11 (36.7%) were get Rs.3000 -.4000, In control group majority of the subjects 11 (36.7%) were get Rs.4001 -.5000.

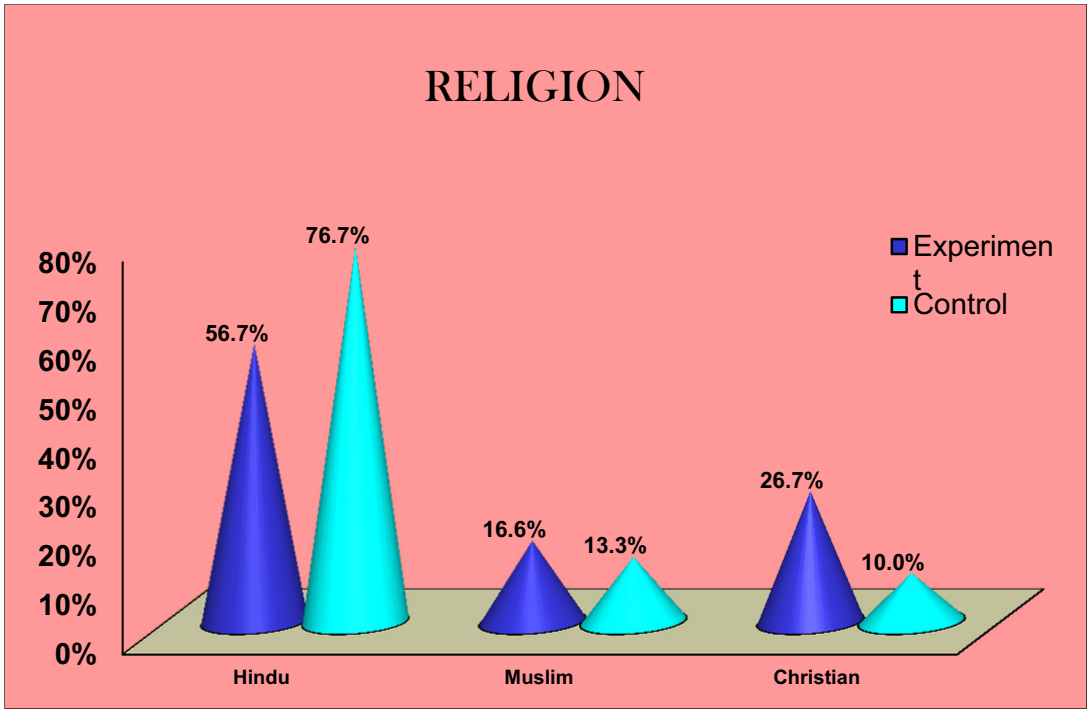


Figure 5 : Multiple cone diagram shows the distribution of primi postnatal mothers in according to their religion.

With regard to religion, majority of the subjects in experimental group 17 (56.7%) belongs to Hindu religion, In control group 23 (76.7%) belongs to Hindu religion.

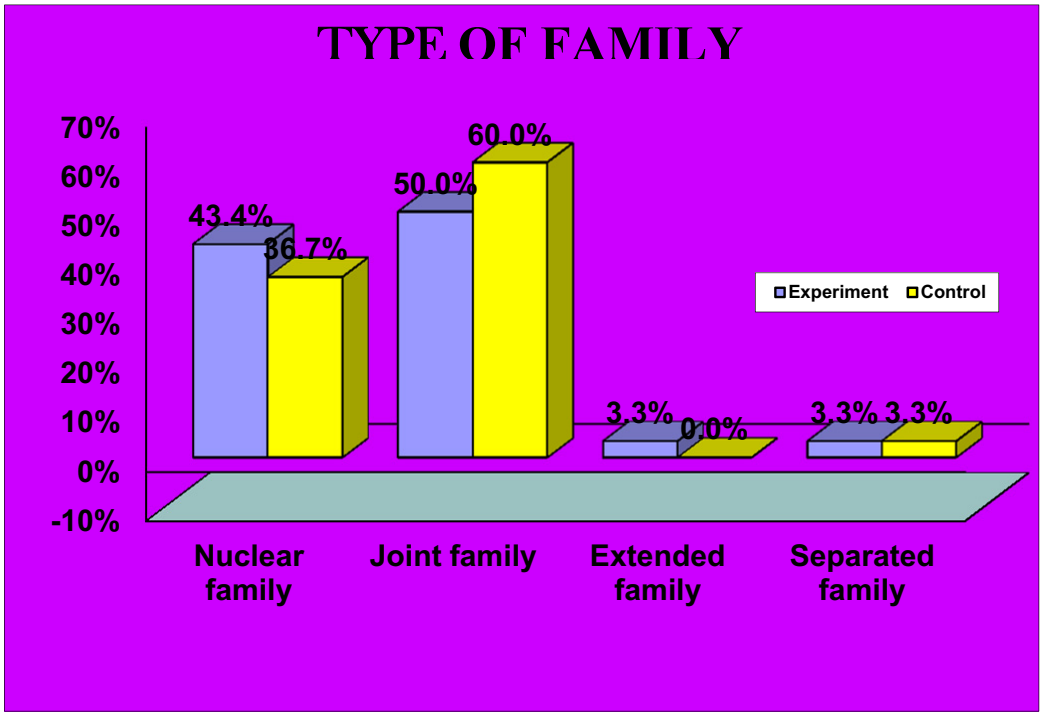


Figure 6 : Multiple bar diagram shows the distribution of primi postnatal mothers in according to their type of family system.

In the aspect of type of family, majority of the subjects in experiment group 15 (43.4%) belongs to joint family and In control group 18 (60%) belongs to joint family.

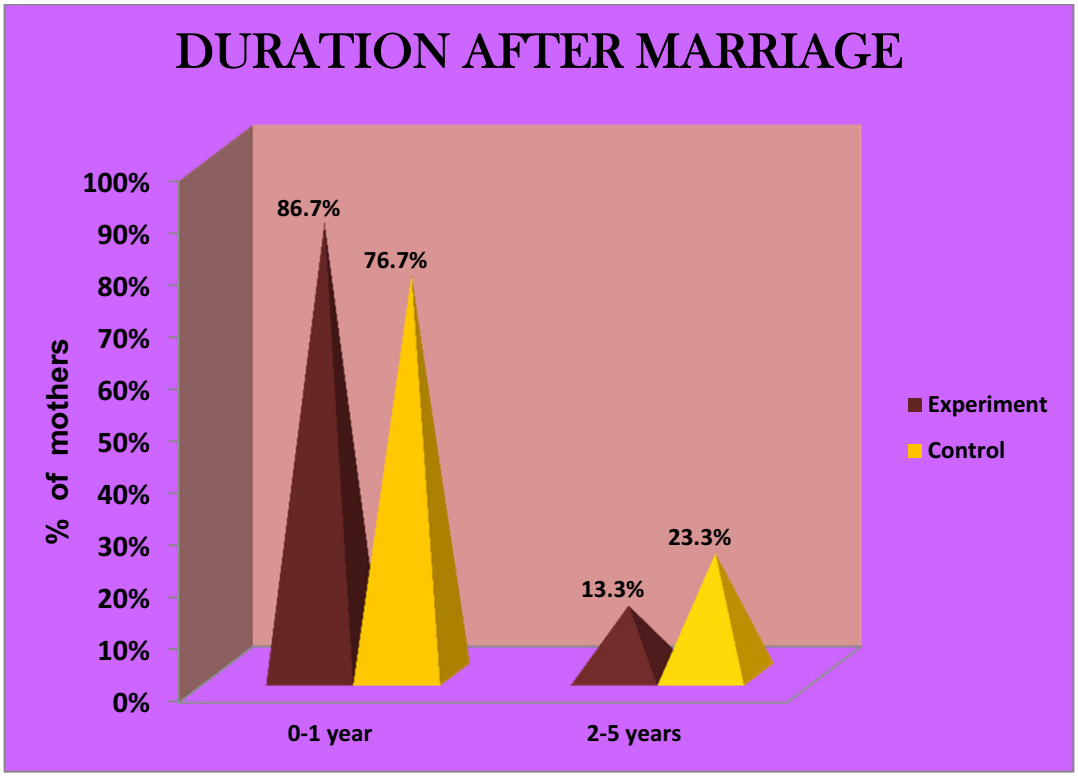


Figure 7: Multiple pyramid diagram shows the distribution of primi postnatal mothers in according to their duration after marriage.

Regarding the duration of marriage, majority of mothers in experimental group 26(86.7%) had 0-1yrs of duration and 4(13.3%) had 2-5yrs of duration. In control group 23(76.7%) had 0-1yrs and 7(23.3%) had 2-5 years.

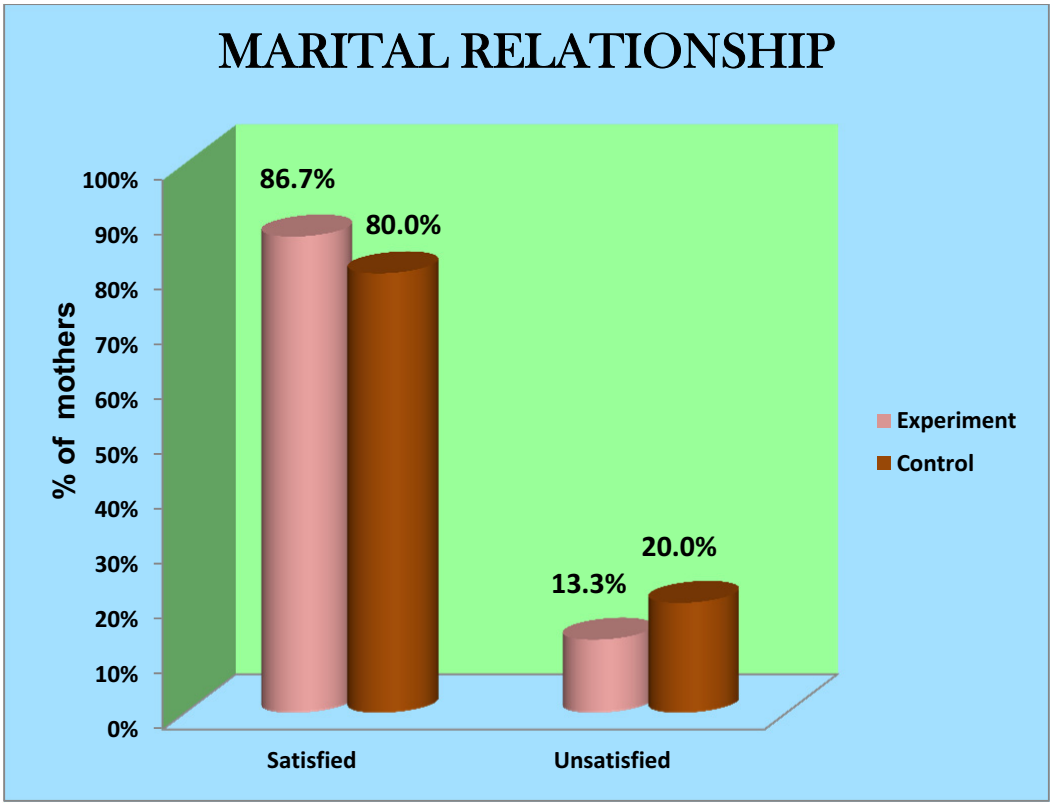


Figure 8: Multiple cylinder diagram shows the distribution of primi postnatal mothers in according to marital relationship.

Considering the marital relationship, majority of the subjects 26(86.7%) were satisfied with their marital relationship in experimental group and 4(13.3%) were unsatisfied marital relationship .In control group 4(13.3%) were satisfied marital relationship and 6(20%) were unsatisfied marital relationship.

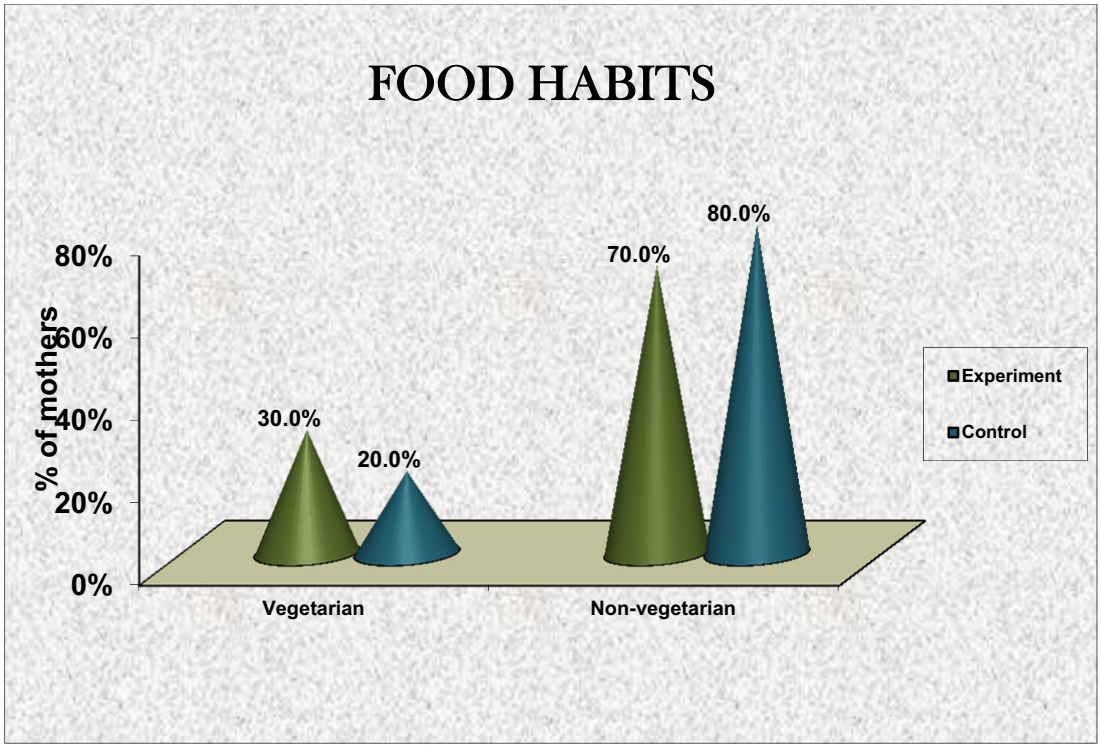


Figure 9: Multiple cone diagram shows the distribution of primi postnatal mothers in according to type of food.

With the view of type of food majority of the subjects in experimental group 9 (30%) were vegetarian, 21 (70%) were non vegetarian. In control group 6 (20%) were vegetarian and 24 (80%) were non vegetarian.

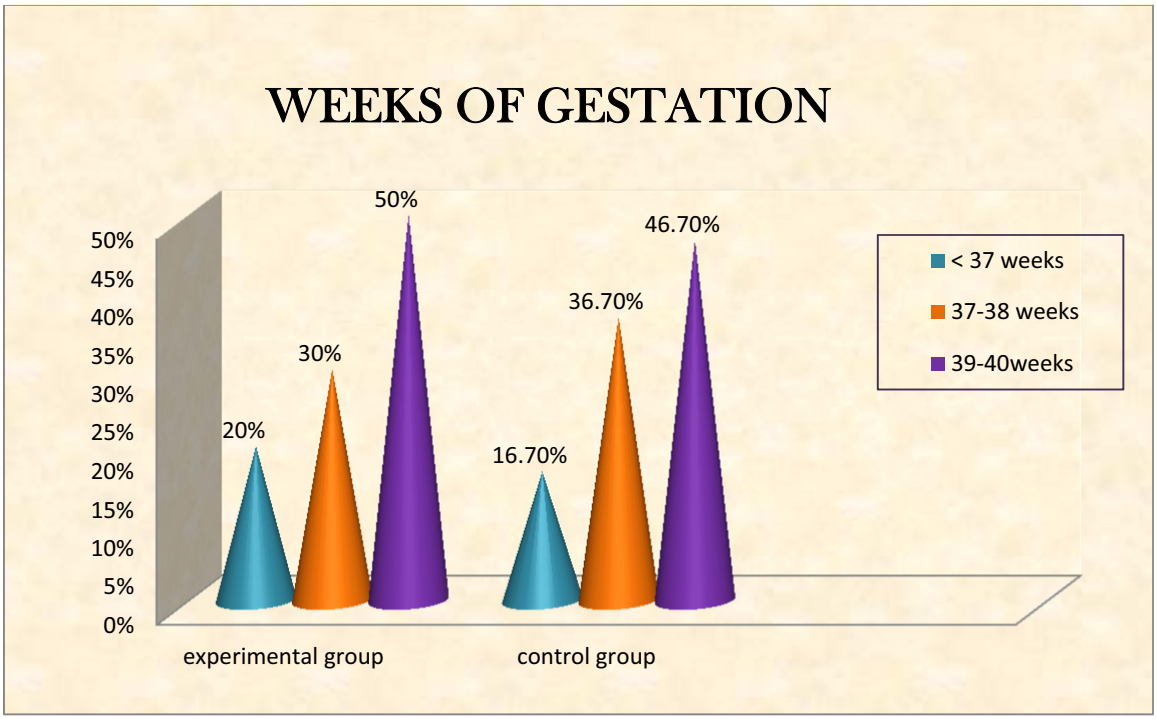


Figure 10 : Multiple cone diagram shows the distribution of primi postnatal mothers in according to weeks of gestation.

This diagram shows weeks of gestation majority of the subjects in experimental group 15(50%) were 39-40 weeks.In control group 14(46.7) were 39-40 weeks of gestation.

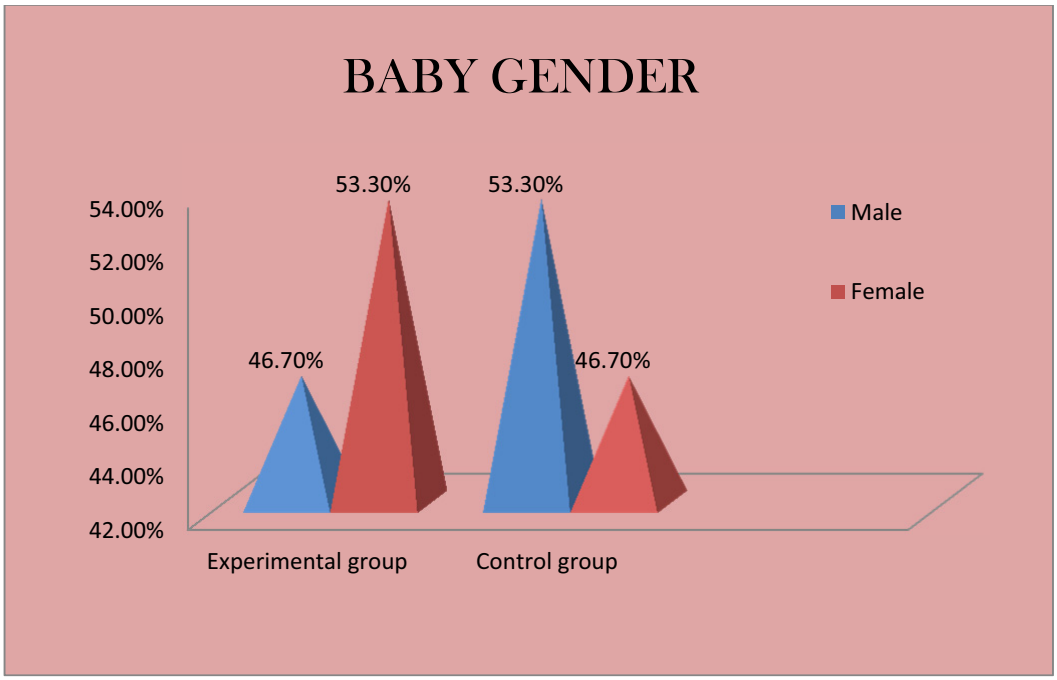


Figure 11 : Multiple pyramid diagram shows the distribution of primi postnatal mothers in according to Baby gender

This diagram shows in experimental group 14 (46.7%) of mothers had male baby and 16(53.3%) had female baby.In control group 16(53.3%) of mothers had male baby and 14(46.7%)) of mothers had female baby.

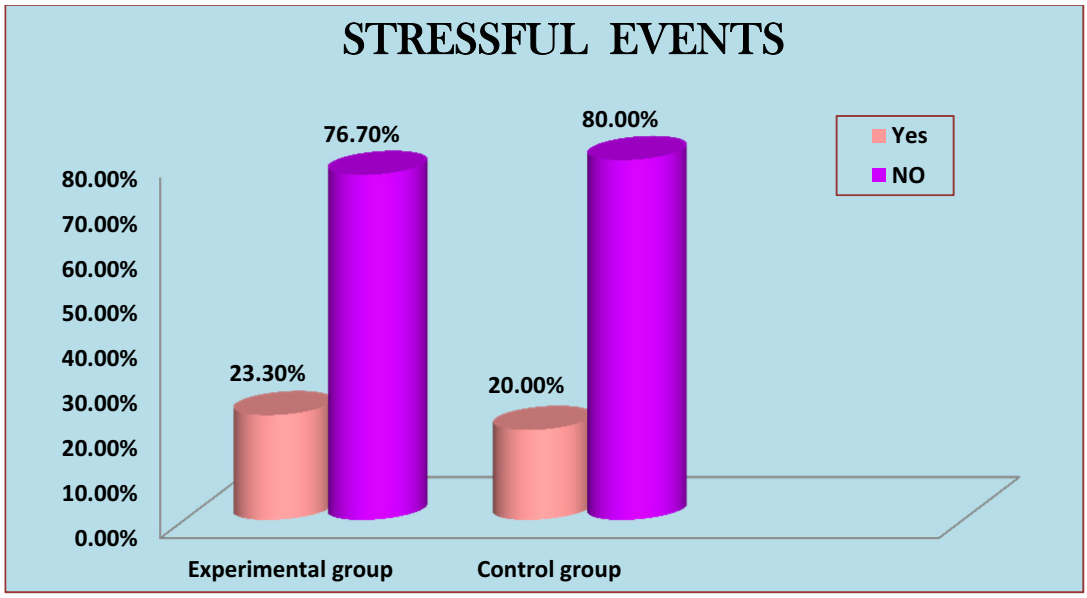


Figure 12 : Multiple cylindrical diagram shows the distribution of primi postnatal mothers in according to Stressful events.

This diagram shows Comparing the stressful events of the mothers life in experimental group 7(23.3%) had stressful events during pregnancy and 23(76.7%)..In control group 6(20%) had stressful events, and 24(80%) had stressful events during pregnancy

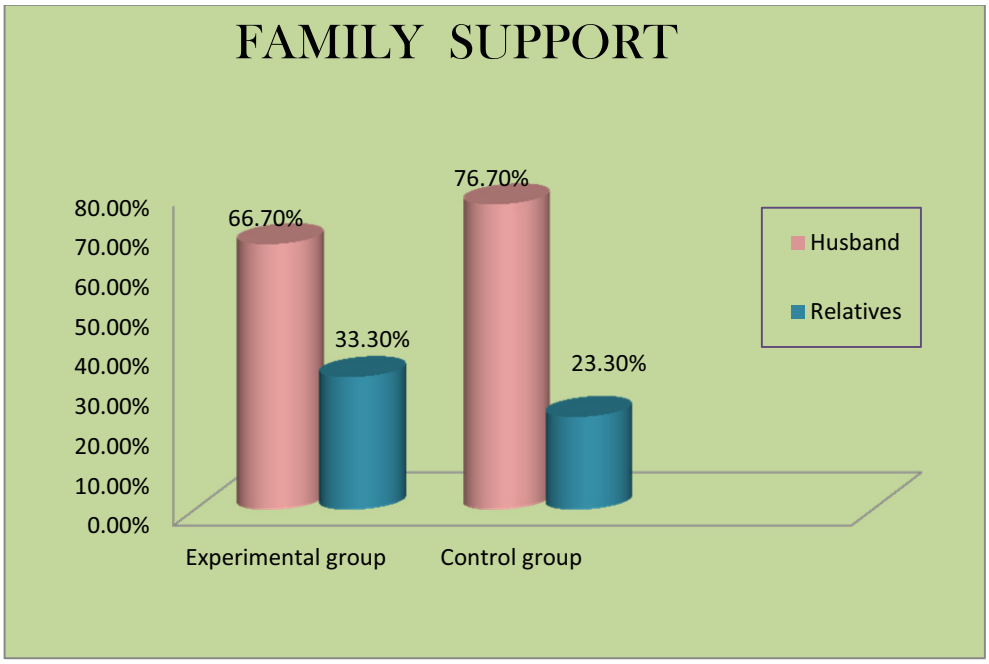


Figure 13 : Multiple cylindrical diagram shows the distribution of primi postnatal mothers in according to Family support.

This diagram shows family support, in experiment group 13 (43.4%) mothers had support by husband and 10(33.3%) mothers had support by relatives. In control group 23(76.7%) mothers had support by husband and 7(23.3%) mothers had support by relatives.

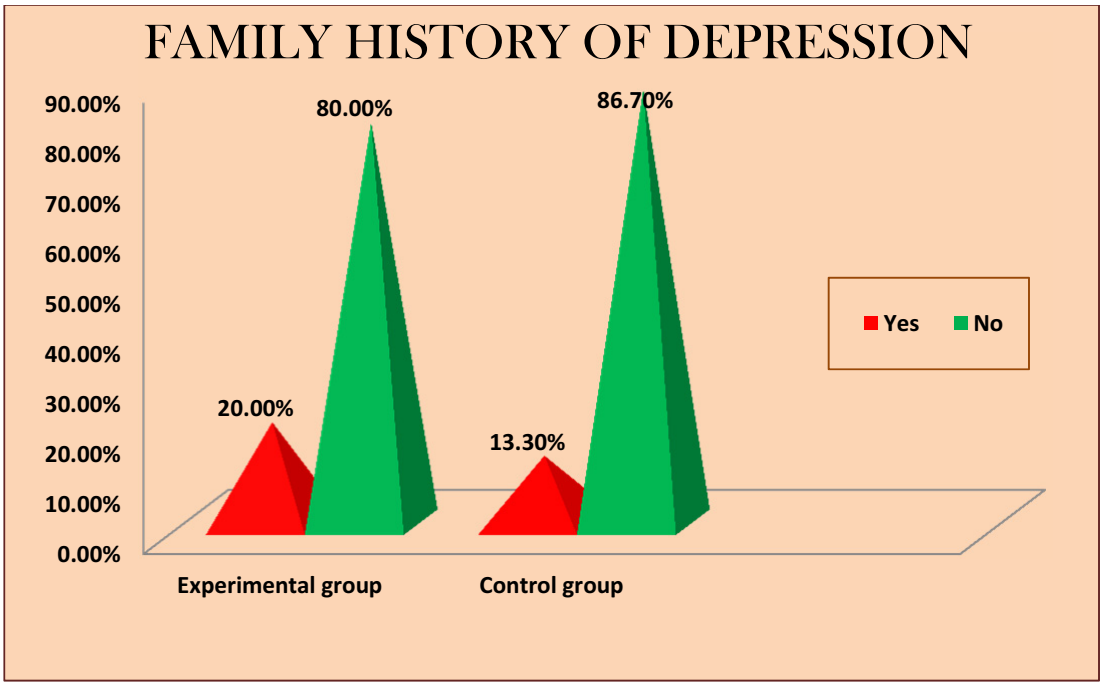


Figure 14: Multiple pyramid diagram shows the distribution of primi postnatal mothers in according to family H/O Depression.

This diagram shows majority of the subjects in experimental group 24(80%) were no family h/o depression and 6(20%) had family h/o depression. In control group majority 26(86.7%) were no family h/o depression and 4(13.3%) had no family h/o depression.

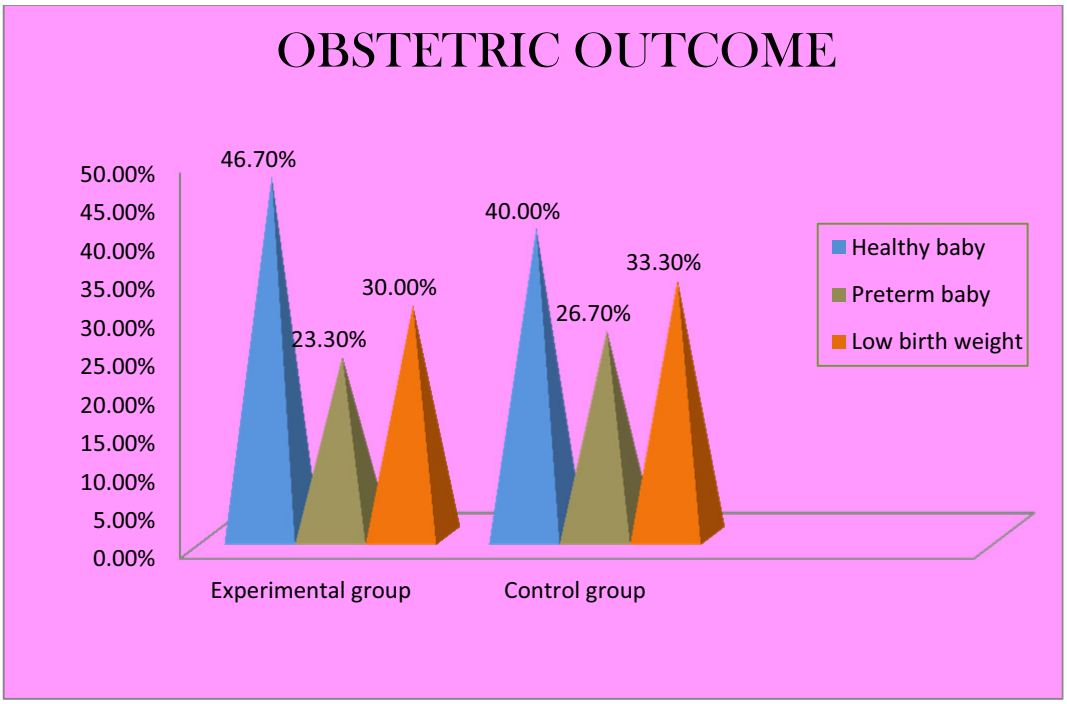


Figure 15 : Multiple pyramid diagram shows the distribution of primi postnatal mothers in according to Obstetric outcome.

This diagram shows obstetric outcome in experimental group 14(46.7%) mothers had healthy baby and 7(23.3%)mothers had preterm baby, 9(30%) mothers had low birth weight baby. In control group 12(40%) mothers had healthy baby and 8(26.7%) mothers had preterm baby, 10(33.3%) mothers had low birth weight baby.

Section III

Table-2 Description of level of postpartum blues among experimental group and control group.

n=60

Level of postpartum blues	Experimental Group		Control Group		Calculated value	Table value	Chi square test
	f	%	f	%			
Mild	26	86.7%	10	33.3%	17.78	5.99	$\chi 2$=17.78 p=0.001*** DF=2
Moderate	4	13.3%	20	66.7%			
Severe	0	0.0%	0	0.0%			

*** significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001**

In posttest , among experiment group, 26 (86.7%) of them are having mild level blues score , 4(13.3%) of them are having moderate level blues score and none of them are having severe level blues score. Among control group, 10(33.3%)of them are having mild level blues score , 20(66.7%)of them are having moderate level blues score and none of them are having severe level blues score Statistically there is a significant difference between experimental and control group postpartum blue scores. Statistical significance was confirmed using chi square test.

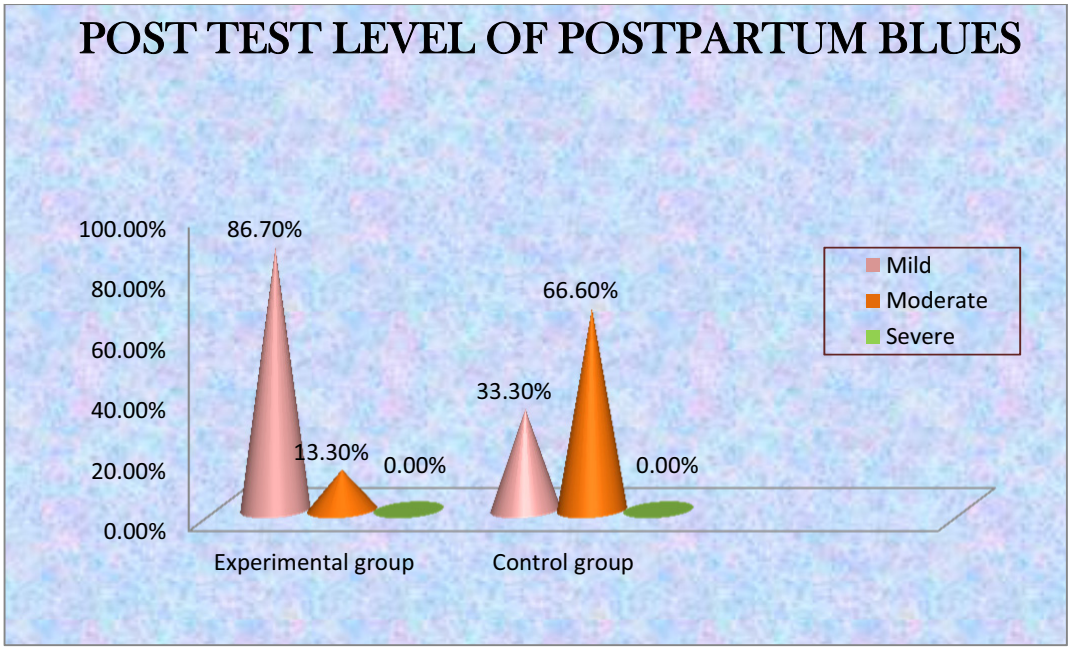


Figure 16: This diagram shows in posttest, among experiment group, 100% of them are having mild level blues score , none of them are having moderate level blues score and none of them are having severe level blues score. Among control group, 33.3% of them are having mild level blues score , 66.7% of them are having moderate level blues score and none of them are having severe level blues score Statistically there is a significant difference between experimental and control group postpartum blue scores. Statistical significance was confirmed using chi square test.

Section III

Table-3 The effectiveness of music therapy of experimental and control group

n=60

Group	Maximum score	Blue score	Mean difference	Mean difference with 95% confidence interval	Percentage difference with 95% confidence interval
Experimental	90	11.63	20.34	20.34 (17.74 –22.91)	22.6% (19.7% - 25.5%)
Control	90	31.97			

This study result shows primi postnatal mothers are having 20.34 postpartum blue score less than control group.. This shows the effectiveness of music therapy on postpartum blues among prim postnatal mothers.

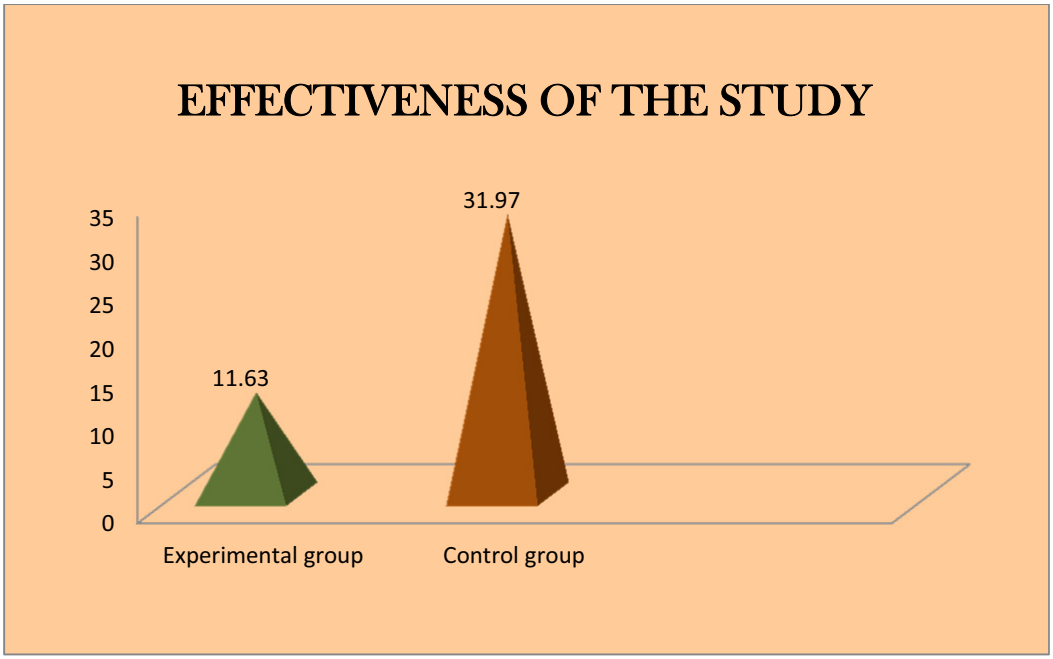


Figure17: This diagram shows that the Experimental group mothers are having 11.63 score and in control group they are having 31.97 score. Difference is 20.33.This difference shows the effectiveness of music therapy on postpartum blues among primi postnatal mothers. This difference is statistically significant. It was confirmed using student independent t-test

SECTION D

TABLE-4

Comparison of the posttest level of blue scores between experimental and control group

Group	No. of post natal mothers	Mean	Std. Deviation	Mean Difference	' t ' -Value
Experimental	30	11.63	4.00	20.34	t=15.75 p=0.001*** DF=58 significant
Control	30	31.97	5.82		

*** significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001**

This table shows that the Experimental postnatal mothers are having 11.63 score and in control group they are having 31.97 score. Difference is 20.34This difference is statistically significant. It was confirmed using student paired t-test

COMPARISON OF POSTPARTUM BLUES SCORE

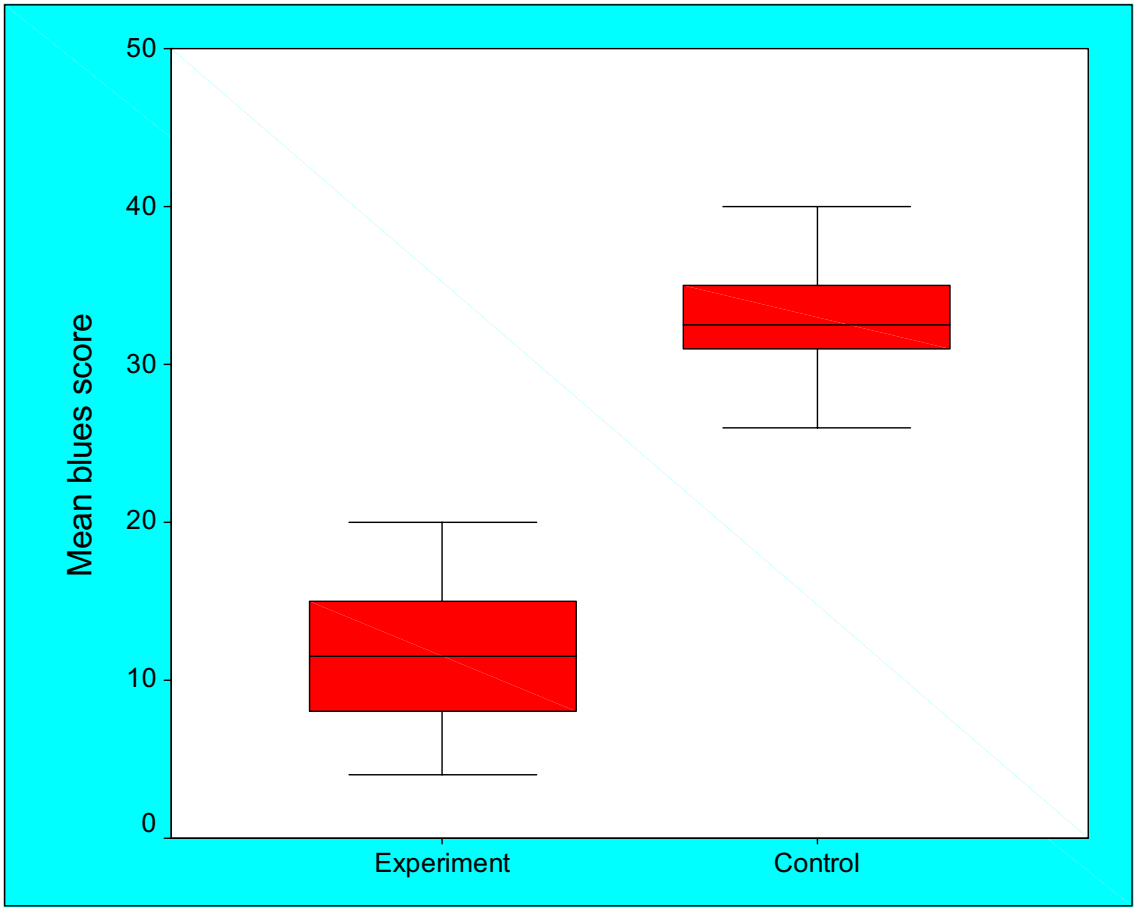


Fig 18: Box plot compare the postpartum blues score among primipostnatal mothers in experimental group and control group

SECTION - E

TABLE-6

Association between posttest levels of postpartum blue score amongexperimentalgroup with demographic variables

Socio demographic variables		Posttest level of blue score						Chi square test
		Mild blues		Moderate blues		Severe blues		
		f	%	f	%	F	%	
Age in years	18 - 22 yrs	11	36.7%	0	0.0%	0	0.0%	**$\chi 2$=5.90 P=0.05***
	23 - 27 yrs	12	40.0%	4	13.3%	0	0.0%	
	28 - 32 yrs	3	10.0%	0	0.0%	0	0.0%	
Education	No formal education	1	3.3%	0	0.0%	0	0.0%	$\chi 2$=0.00 P=1.00
	Primary education	12	40.0%	0	0.0%	0	0.0%	
	Higher secondary education	13	43.4%	0	0.0%	0	0.0%	
	Graduate	4	1 3.3%	0	0.0%	0	0.0%	
Occupation	Home maker	24	80.0%	0	0.0%	0	0.0%	$\chi 2$=0.0 P=1.00
	Daily wages	3	10.0%	0	0.0%	0	0.0%	
	Private employee	2	6.7%	0	0.0%	0	0.0%	
	Government employee	1	3.3%	0	0.0%	0	0.0%	
Income	Rs.3000-4000	11	36.7%	0	0.0%	0	0.0%	$\chi 2$=0.00 P=1.00
	Rs.4001-5000	10	33.3%	0	0.0%	0	0.0%	
	Rs.5001-6000	4	13.3%	0	0.0%	0	0.0%	
	Rs.>6000	5	16.7%	0	0.0%	0	0.0%	
Religion	Hindu	17	56.7%	0	0.0%	0	0.0%	$\chi 2$=0.00 P=1.00
	Muslim	5	16.6%	0	0.0%	0	0.0%	
	Christian	8	26.7%	0	0.0%	0	0.0%	
Type of family	Nuclear family	13	43.4%	0	0.0%	0	0.0%	$\chi 2$=0.00 P=1.00
	Joint family	15	50.0%	0	0.0%	0	0.0%	
	Extended family	1	3.3%	0	0.0%	0	0.0%	
	Separated family	1	3.3%	0	0.0%	0	0.0%	

Demographic variables		Posttest level of blue score						Chi square test
		Mild blues		Moderate blues		Severe blues		
		f	%	f	%	f	%	
Duration After marriage	0-1 year	26	86.7%	0	0.0%	0	0.0%	$\chi 2=0.00$
	2-5 years	4	13.3%	0	0.0%	0	0.0%	P=1.00
Marital relationship	Satisfied	26	86.7%	0	0.0%	0	0.0%	$\chi 2=0.00$
	Unsatisfied	4	13.3%	0	0.0%	0	0.0%	P=1.00
Food habits	Vegetarian	9	30.0%	0	0.0%	0	0.0%	$\chi 2=0.00$
	Non-vegetarian	21	70.0%	0	0.0%	0	0.0%	P=1.00
Weeks of gestation	< 37 weeks	3	10.0%	3	10.0%	0	0.0%	**$\chi 2=9.32$**
	37-38weeks	8	26.7%	1	3.3%	0	0.0%	**P=0.01***
	39-40 weeks	15	50.0%	0	0.0%	0	0.0%	
Baby gender	Male	14	46.7%	0	0.0%	0	0.0%	$\chi 2=0.00$
	Female	16	53.3%	0	0.0%	0	0.0%	P=1.00
Stressful events During	Yes	4	13.3%	4	13.3%	0	0.0%	**$\chi 2=6.88$**
	No	23	76.7%	0	0.0%	0	0.0%	**P=0.01***

* significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

Demographic variables		Posttest level of blue score						Chi square test
		Mild blues		Moderate blues		Severe blues		
		f	%	f	%	f	%	
Family support	Husband	20	66.7%	0	0.0%	0	0.0%	$\chi 2=0.00$
	Relatives	10	33.3%	0	0.0%	0	0.0%	P=1.00
Family H/O Depression	Yes	6	20.0%	0	0.0%	0	0.0%	$\chi 2=0.00$
	No	24	80.0%	0	0.0%	0	0.0%	P=1.00
Obstetric outcome	Healthy baby	14	46.7%	0	10.0%	0	0.0%	**$\chi 2=7.47$**
	Preterm baby	4	13.3%	3	0.0%	0	0.0%	**P=0.02***
	Low birth weight	8	26.7%	1	3.3%	0	0.0%	

* significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

The above table shows that there issignificant association between level of postpartum blue score and selected socio demographic variables elder womenare less postpartum blues than others. Statistical significance was calculated by using chi square test.

The association between Level of postpartum blue score and Women obstetrical variables of experiment group. The postnatal women had no stressful events during pregnancy and who having healthy baby are less postpartum blues than others. Such as Age in years, Weeks of gestation,Stressful events during pregnancy, Obstetric outcome, Statistical significance was calculated by using chi square test.

SUMMARY

CONCLUSION,

IMPLICATION &

RECOMMENDATIONS

CHAPTER V

DISCUSSION

This chapter deals with the detailed discussion of the results of the data interpreted through statistical analysis. The focus of the study was to assess the effectiveness of music therapy on postpartum blues among postnatal mothers the age between 18-32 years in postnatal ward at Government Rajaji Hospital Madurai. The investigator adopted true experimental design. 60 postnatal women were selected and having postpartum blues. The level of postpartum blue score was assessed by Standardized Am I Blue ? Questionnaire. The results are discussed according to the objectives and supporting studies.

Findings based on demographic variables

With the respect to the age limit of the mothers between 18-22yrs in experimental group were 11(36.7%) and 16(53.3%) were 23-27 yrs and 3(10%) mothers were 28-32 years. Whereas in the control group it were 9(30%) were 18-22 years and 14(46.7%) was 23-27 years and 7(23.3%) mothers were 28-32 years of age.

With the view of educational status, in the experimental group,1(3.3%)women were no formal education and 12(40%) of mothers were finished their primary education and 13(43.4%)of mothers were completed their higher secondary education and 4(13.3%) were graduate but in the control group 3(10%) were no formal education and 11(36.7%) were primary education and 11(36.7%) were completed their higher secondary education and 5(16.6%) were graduate.

In the view of occupation, In the view of occupational status majority of the subjects in experimental group 24 (80%) were home maker and 3 (10%) were daily

wages.,2(6.7%) were working as a private employee,1(3.3%) were working as government employee. In control group 23(76.6%) were home maker and 3 (10%) were daily wages.,2(6.7%) were working as a private employee,2(6.7%) were working as government employee..

Considering the monthly income majority of the subjects in experimental group majority of the subjects 11 (36.7%) were get Rs.3000 -.4000, And 10 (33.3%) were get Rs. 4001-5000, and 4(13.3%) were get Rs.5001-6000 and 5(16.7%) were get Rs.> 6000. In control group majority of the subjects 11 (36.7%) were get Rs.4001 -.5000, and 4 (13.3%) were get Rs 3000-4000, and 6(20.0%) were get Rs. 5001-6000/-. and 9(30.0%) were get Rs.> 6000.

With regard to religion, In experimental group 17 (56.7%) belongs to Hindu religion, 5(16.6%) belongs to Muslim and 8(26.7%) were belongs to Christian. In control group 23 (76.7%) belongs to Hindu religion, 4(13.3%) belongs to Muslim and 3(10.0) belongs to Christian.

In the aspect of type of family, in experiment group 13 (43.4%) belongs to nuclear family, 15 (43.4%) belongs to joint family and 1(3.3%) were belongs to extended family, 1(3.3%) belongs to separated family. In control group 11 (36.7%) mothers were belongs to nuclear family, 18 (60%) belongs to joint family, only one (3.3%) mother were belongs to separated family.

Regarding the duration of marriage, majority of mothers in experimental group 26(86.7%) mothers were 0-1 yrs of duration and 4(13.3%) mothers were 2-5yrs of duration. In control group 23(76.7%) mothers were 0-1yrs and 7(23.3%) mothers were 2-5 years of duration.

Considering the marital relationship, majority of the subjects 26(86.7%) mothers were satisfied with their marital relationship in experimental group and 4(13.3%) mothers were unsatisfied marital relationship. In control group 4(13.3%) mothers were satisfied marital relationship and 6(20%) had unsatisfied marital relationship.

With the view of habits majority of the subjects in experimental group 9 (30%) were vegetarian, 21 (70%) were non vegetarian. In control group 6 (20%) mothers were vegetarian and 24 (80%) were non vegetarian.

With the aspect of weeks of gestation in experimental group 6 (20%)mothers were< 37 weeks and 9 (30%) mothers were 37-38 weeks of gestation and 15(50%) mothers were 39-40 weeks. In control group 5(16.7%) were < 37 weeks 11(36.7%) were 37-38 weeks and 14(46.7) were 39-40 weeks of gestation.

Regarding this study in experimental group 14 (46.7%) of mothers had male baby and 16(53.3%) had female baby. In control group 16(53.3%) of mothers had male baby and 14(46.7%)) of mothers had female baby.

Comparing the stressful events of the mothers life in experimental group 7(23.3%) had stressful events during pregnancy and 23(76.7%).In control group 6(20%) had stressful events and 24(80%) had stressful events during pregnancy.

In the view of family support, in experiment group 13 (43.4%) mothers were support by husband and 10(33.3%) mothers were supported by relatives. In control group 23(76.7%) mothers were support by husband and 7(23.3%) mothers had supported by relatives.

With the view of majority of the subjects in experimental group 24(80%) were no family h/o depression and 6(20%) had family h/o depression. In control group majority 26(86.7%) were no family h/o depression and 4(13.3%) had family h/o depression.

In the aspect of obstetric outcome in experimental group 14(46.7%) mothers had healthy baby and 7(23.3%)mothers had preterm baby, 9(30%) mothers had low birth weight baby. In control group 12(40%) mothers had healthy baby and 8(26.7%) mothers had preterm baby, 10(33.3%) mothers had low birth weight baby.

Findings based on objectives

The first objectives was to assess the level of postpartum blues score among primi postnatal mothers in experimental and control group in postnatal ward at Government Rajaji Hospital, Madurai.

The level of Postpartum blue among postnatal mothers in experimental group majority 26(86.7%) mothers were having mild postpartum bluesand 4(13.3%) mothers were having moderate postpartum blues, 20 (66.7%) of the postnatal mothers in the control group were having moderate postpartum blue,10(33.3%) of the postnatal mothers were having mild postpartum blues.

This study can be compared to the study conducted by **Sun mi lee (2010),** 60 puerperal women were recruited (30 in the experimental group, 30 in the control group). music therapy was provided to the experimental group over 30 min, once a day, and for 5 days. Then, postpartum blues and maternal attachment for the experimental and control group were measured again on the 5th day. The data were analyzed using the SPSS WIN 12.0 Program**.** The first hypothesis that "the degree of postpartum blues for the experimental group who participated in music therapy would

be lower than that of the control group" was accepted (t=4.350, p<.001). The second hypothesis that "the degree of maternal attachment of the experimental group who participated in music therapy would be higher than that of the control group" was accepted (t= 4.828, p<.001). These findings indicate that music therapy has positive influences on decreasing postpartum blues and increasing maternal attachment of puerperal women.

Cathy H.Mckinney,(2013) conducted a study to Maternity blues psychological factors by using the Maternity Blues Scale (MBS) and. The answers "Having a friend I can talk to about maternity life or child rearing" [β (95% confidence interval) = –1.53 (–2.68 – –0.378)] and a Japanese traditional support system wherein a postnatal woman lives with her husband/parents [–2.82 (–4.73 – – 0.898)] were significantly associated with MBS scores., although the association between the partner's age and these scores was marginally significant [–0.106 (–0.008 – 0.221)]. This study shows that it is important to provide support for healthy women without delivery complications, both at home and in the community.

2. The second objectives was to evaluate the effectiveness of music therapy on postpartum blues among primi postnatal mothers in experimental group admitted in postnatal ward at Government Rajaji Hospital, Madurai.

After sample selection music therapy was given to the mothers with postpartum blues daily twice a day for 4 weeks. After the intervention assessed the level of postpartum blues by using Am I Blue ? Questionnaire. The majority of the subjects among control group post test score is 10(33.3%) of women were having mild blues, 20 (66.7%) women were having moderate blues. Majority of the subjects among in experimental group 26(86.7%) mothers were having mild postpartum

blues and 4(13.3%) mothers were having moderate postpartum blues,. Mean and Standard Deviation of post test blues scores of Control group (M=31.97, SD=5.82) and Experimental group (M=11.63, SD=4.00). The unpaired t test value showed statistically significant difference between the postpartum blue scores on experimental and control group.(t-15.75 P- 0.001). The difference was found to be statistically significant at 0.001 levels and can be attributed to effectiveness of music therapy.

Mrs.Shanmugam Rajamani, (2012) was conducted the study to evaluate the effectiveness of complementary and alternative therapies in terms of postnatal blues. A quantitative study ,experimental design,60 samples, guided imagery was given by using Walkman and visual stimulation .there was no association between the postnatal blue score and type of family of the postnatal mothers in the experimental group. there was a significant negative correlation between postnatal blues and self esteem among postnatal mothers (-0.96)at0.05 level of significance.

Angel Rajakumari.G. Sheela,R.(2013) The study was conducted in Vijayalakshmi Hospital, in suryapet. The postnatal mothers were recruited by non-probability purposive sampling technique, music was given by investigator for 20 minutes again the same step is repeated in a 10 minutes interval. Post test was assessed without administering the music for the control group. In the experimental group, the investigator assessed the level of postpartum blue score by using modified am I blue questionnaire. The postnatal mothers completed the demographic and obstetrical information. This study revealed that there was high significant difference found in postpartum blues at $p<0.001$level between experimental group. The study concluded that, clinical implementation of music therapy usage during postpartum

period could be an effective non pharmacological intervention in reducing postpartum blues.

Thus the hypotheses - (H_1):"There is a significant difference between postpartum blues scores among primi postnatal mothers in experimental group and control group in postnatal ward at Government Rajaji Hospital, Madurai." was accepted.

3. The third objectives of the study was to associate post test level of the postpartum blue scores among primi postnatal mothers in experimental group with their selected socio demographic and obstetric variables.

Statistical association between the post test score and selected demographic variables were calculated in both group experimental and control group using Chi square test. In experimental group the results showed that there was a significant association found between the post test level of postpartum blues score and selected socio demographic variables and obstetric variables like Age in years (**$\chi 2=5.90$**). Weeks of gestation,(**$\chi 2=9.32$**) Stressful events during pregnancy(**$\chi 2=6.88$**), Obstetric outcome(**$\chi 2=7.47$**).In experimental group the calculated χ^2 value 15.75 at calculated P value is 0.01 .

Thus the hypotheses -H_2: "There is a significant association between the level of postpartum blues score among primi postnatal mothers in experimental group with their selected socio demographic and clinical variables in postnatal ward at Government Rajaji Hospital, Madurai." was accepted.

REFERENCES

REFERENCES

TEXT BOOKS

1. Adelle Pillitery, (2006). *Maternal and Child Health Nursing.* (2nd Eds).New Delhi:Lippincott and Williams Publishers.
2. Ann MarrianerTomy&MarthRouileAlligood, (1998). *Nursing Theories and their work*. Mosby: Philadelphia.
3. Basavanthapa, B.T. (2006). *Textbook of midwifery and reproductive health*.New Delhi: Jaypee Brothers Company.
4. Berek.S.Jonathan,(2007).*Gynacology*.(14th eds).New Delhi: WoltersKluwers private limited.
5. Bhargarva,VL.(2009).*Text book of Gynecology*.(2nd eds).Newdelhi: Ane books pvt.Ltd.
6. Bobak Jensen,(2009). *Maternity and Gynecologic Care*. (5th Eds).New Delhi: Mosby Publication.
7. Brown.K. Linda, BennetRuth,V. (2010). *Myles text book for midwives*. (12 thed). NewYork: Churchill living stone.
8. Danfortis.(2010),*Obstetrics &Gynecology*.Calcutta: (9th Eds).Lippincott & Williams Publication.
9. Dannel, E. Shaon, Wong and perry, (1998). *Maternal and child nursing care*. C.V. Mosby: Philadelphia.
10. Denise, F. Polit&chery Tatano beck. (2004). *Nursing Research*. (7 thed). New Delhi: Lippincott Williams and Wilkins.
11. Dorothy, R. Marlow & Barbara C. Redding. (1998). *Textbook of pediatric Nursing,* (6 thed) . Piladelphia: Saunders.

12. Dutta, D. C. (2004). *Text book of gynaecology including perinatology* and contraception. (6 thed). Kolkatta: New central book agency (p) Ltd.
13. Dutta,D. C. (1998). *Text book of obstetrics*. (5 thed). Calcutta: New central book agency.
14. Fawcett Jacquiline, (1989). *Analysis and evaluation of conceptual Model of Nursing.* Philadelphia: F.A. Davis.
15. Geri Lobiondo-Wood, & Judith Haber. (2006). *Nursing Research*. **(**6th ed.). St. Louis: Mosby publications.
16. Ghai, O.P. (2004). *Essential pediatrics*. (6th ed.). New Delhi: CBS publisher .
17. Gupta, S.P. (1991). *Statistical Methods*. (3rd ed.). New Delhi: Sultan Chand.
18. Indrani,TK. (2003). *Textbook of Midwifery.* New Delhi: Jaypeebrothers medical publishers.
19. Irene, Bobak, M. & Jensen Duncan Margret. (1995). *Essentials of maternity nursing.* (4 thed). C. V. Mosbys: Philadelphia.
20. Jacob Annamma, (2008). *A comprehensive text book of midwifery.* (2 nded). New Delhi: Jaypee publications.
21. Jill Mantle, JeanettHaslam,Suebarton. (2006). *Physiotherapy in Obstetrics and Gynaecology*. (2nd Eds). London: Elsevier ltd.
22. JohShidd, (2005). *Progress in Obstetric Gynecology*. United kingdom: Elsevier sciences ltd.
23. John.O.Schorge, Joseph.I.Schaffers, Lisa Halvorson.(2008). *Williams Gynecology*.(2nd ed).China: McGraw Hill companies
24. Kothari, (2000). *Text book of methodology*. (2nd ed). NewDelhi: Vishvaparkson publication.

25. Krishna Menon,MK.Palaniappan.(2003).*Clinical obstetrics*.(9thEds)Chennai: Orient longmen private ltd.
26. Lakshmi Seshadri,(2011*).Essentials of Gynecology*.New delhi:Wolters Kluwer
27. LowdermilkDiettraleonard,& Perry E Shannon . (2007). *Maternity and woman health*. (9 thed). Missouri: Mosby Elseiver.
28. Lynner,Y.Littleton.etal., *Maternal neonatal and woman health Nursing*.(1 sted).Canada: Delmar Company
29. M C Kinney, (2009). (2ndEds).*Maternal-Child Nursing*. Philadelphia Elsevier publishers.
30. McMillan,J.H. (1989). *Research in education conceptual introduction.*(1 sted) New York: Harper collies.
31. Nancy Burns, & Susan K Grove. (2007). *Understanding Nursing Research***.** **(**4th ed)
32. Nicki L.Potts, (2009). *Text book of Paediatrics*. (11th ed.). New Delhi: Jaypee publications.
33. Padubidri,VG.,ElaAnand.(2005). *Gynaecology*.New Delhi: Elsevier India private limited.
34. Panay, Dutta, Ryan., Broadbent.(2005).*Obstetrics and Gynaecology*. London: Mosby publishers
35. ParulDatta, (2009). *Paediatric Nursing.* (2ndeds.). New Delhi: Jaypee publications.
36. Philip.N.Baker. (2006).*Obstetrics by ten teachers*.(16thEds). India:Jaypee brothers medical publishers.
37. Polit, Hungler. (2004). *Nursing Research Principles and Methods*. (6 thed) Philadelphia: Lippincott Company.

38. Reede,(2006).(18th Eds).*Maternity Nursing*. Philadelphia: Lippincott publishers.

39. RichaSaxena, (2012). *Snapshots in obstetrics and gynecology*. Newdelhi: Jaypeebrothers medical publishers.

40. Roger,P.Smith.(2002). *Netter's Obstetric Gynaecology and women's health*. Canada: Icon learning systems

41. Rose Marie Linda, (2008). *Foundations of Nursing Research.* (5th ed.). New Delhi: Pearson

42. RuthBennet,V.(2005).(14 Eds).*Myles Text Book for Midwives*. Calcutta:English Language Book Society

43. Sharon Smith Murray, et.al. (2006). *Foundation of maternal and newborn nursing*. (4 thed). Philadelphia: Saunders Company.

44. Shashank,V.(2000).*Handbook of practical gynaecology and obstetrics*. Mumbai: Vora medical publishers,

45. Sodashy,&Yalfe, B.J. (1993). *Nursing theory analysis application and evaluation*. (2 nded) Boston: Little Brown.

46. Sunders Rao, PS. (1990). *An introduction to biostatistics.* (3 rded). New Delhi: prince hall publications.

47. Susan, A.Orshan.(2008). *Maternity, Newborn & women's Health Nursing*. New Delhi: Lippincott & Williams Publication.

48. Thresamma,CP. (2006). *A guide to Midwifery students*. India: Jaypeebrothers medical publishers.

JOURNAL REFERENCES

1. Chang, M. Y., Chen, C. H., & Huang, K. F. (2015). Effects of music therapy on psychological health of women during pregnancy. Journal of Clinical Nursing, 17(19), 2580-2587.
2. Columba K, Mbekenga. Joy, struggle and support; Post-partum experiences of first-time mothers in Tanzanian suburb. Journal of Women and Birth. MAR 2014; 24(1): 24-31.
3. Freidrich, M. J. (2014). Institute probes music's therapeutic potential. JAMA: the journal of the American Medical Association, 291(13), 1554-1555.
4. Gale, S., & Harlow, B. L. (2013). Postpartum mood disorders :A review of clinical and epidemiological factors. Journal of Psychosomatics Obstetrics and Gynecology,24(4):257-66.
5. Chung SS, YOOIY, Joung KH(2013). Postpartum blues among Korean mothers: A structural education modeling approach. International journal of mental health nursing.
6. Caryl Ann Browning, (2012),Journal of Birth, Volume 27**,** pages 272–276.
7. Feng Huang (2012), "Special Issue: Complementary and Alternative Medicine" Journal of Clinical Nursing, Volume 17, pages 2580–2587.
8. Cevasco, A. M. P. M. T. B. C. N.-M. T. (2012). The Effects of Mothers' Singing on Full-term and Preterm Infants and Maternal Emotional Responses. Journal of Music Therapy, 45(3), 273-306.
9. Friedman, S. H., Kaplan, R. S., Rosenthal, M. B., & Console, P. (2011). Music Therapy in Perinatal Psychiatry: Use of Lullabies for Pregnant and Postpartum Women with Mental Illness. Music and Medicine, 2(4), 219-225.

10. Gard, P. R., Handley, S. L., Parsons, A. D., &Waldrom, G. (2010).A multivariate investigation of postpartum mood disturbance.British Journal of Psychiatry, 148567-75.
11. Hannah, P., Adams, D., Lee, A., Glover, V., & Sandler, M. (2009). Links between early post-partum mood and post-natal depression. The British Journal of Psychiatry, 160(6), 777-780.
12. Adewuya, A. O. (2009) The maternity blues in Western Nigerianwomen: prevalence and risk factors. American Journal of Obstetrics and Gynecology, 193(4):1522-5.
13. Hapgood, C. C., Elkind, G. S., & Wright, J. J. (2009). Maternity blues: Phenomena and relationship to later postpartum depression. Australian and New Zealand Journal of Psychiatry**,** 22:299-306.
14. Henshaw, C. (2008). Mood disturbance in the early puerperium: a review. Arch Women Ment Health; 6 Suppl 2:S33-42.
15. Gath D, Kennerley H (2008). Maternity blues. II. A comparison between post-operative women and post-natal women. Br J Psychiatry; 155; 363-366 .
16. Lucy Newmark Sammons , (2008),Journal of Nurse-Midwifery, Volume 29, Pages 266-270,
17. Seyfried, L.S., & Marcus, S. M. (2003). Postpartum mood disorders. International Review of Psychiatry,15(3):231-42.
18. Honey, K. L., Bennett, P., & Morgan, M. (2002). A brief psycho-educational group intervention for postnatal depression. The British Journal of Clinical Psychology, 41, 405-409.

19. Nappi, Rossellae, Petraglia, Felice, Luise, Stefano. “To Relate Serum allopregnanolone and progesterone levels postpartum to maternity”. Department of obstetrics and gynecology, January 2001, Volume 97,Pp:77-80.
20. Lane, A., Kelville, R., Morriss, M., Kinsella, A., Turner, M., & Barry, S. (1997). Postnatal depression and elation among mothers and their partners: prevalence and predictors. British Journal of Psychiatry, 171:550-5.
21. Lanczik, M., Brown, G., & Stump, K. (1992). Post-partum blues: Depressive disease of pseudo neurasthenic syndrome. Journal of Affective Disorders, 25:47-52.
22. Kennerly, H., & Gath, D. (1989). Maternity blues: I. Detection and measurement by questionnaire. British Journal of Psychiatry,155:356-62.
23. Pitt, B. (1973). Maternity blues. British Journal of Psychiatry, 22:431-3.
24. R nancy .hazle ,S.N.M,B.S.N. Post partum blues assessment and intervention. journal of nurse midwifery.1982 Nov-Dec;27(6):21-25.
25. Stein, G. S. (1980). The pattern of mental changes and body weight change in the first post-partum week. Journal of Psychosomatic Research, 24:165-71.

NET REFERENCES

- http://www.ccn.aacnourals.org
- http://www.expressindia.com
- http://does.google.com
- http://www.unimondo.org
- Http://www.anaemia.org
- Http;//www.hinduonnet.com
- http://web.worldbank.org/
- Http://cat.inist.Fr/
- http://journal.shouxi.net/html/qikan
- Http://www.clinmedres.org
- http://FHI.org/
- www.ICrw.org/does/
- http://bccentrefordisesecontrol.org
- http://www.clincaltrials.gov
- http://www.currentnursing.com
- http://www.konjacfoods.com/fiber.htm
- http://www.medscape.com
- http://mohfw.org/nhp
- http://www.ncbi.nlm.nih.gov
- http://www.nursingtimesnet
- http://www.pubmed.com
- http://www.sciencedirect.com
- http://www.thecochranelibrary.com

ANNEXURES

APPENDIX-I

ETHICAL COMMITTEE APPROVAL TO CONDUCT THE STUDY

Ref.No.10189/E1/5/2014

Madurai Medical College,
Maduai -20. Dated: 13-10.2014.

Institutional Review Board/Independent Ethics Committee
Capt.Dr.B.Santhakumar,MD (FM). deanmdu@gmail.com
Dean, Madurai Medical College &
Government Rajaji Hospital, Madurai 625 020 . Convenor

Sub: Establishment – Madurai Medical College, Madurai-20 –
Ethics Committee Meeting – Meeting Minutes - for October 2014 –
Approved list – reg.

The Ethics Committee meeting of the Madurai Medical College, Madurai was held on October 15th 2014 at 10.00 Am to 12.00 Noon at Anaesthesia Seminar Hall at Govt. Rajaji Hospital, Madurai . The following members of the Ethics Committee have attended the meeting.

1.Dr.V.Nagarajan,M.D.,D.M(Neuro) Ph: 0452-2629629 Cell No.9843052029 nag9999@gmail.com.	Professor of Neurology (Retired) D.No.72, Vakkil New Street, Simmakkal, Madurai -1	Chairman
2.Dr.Mohan Prasad, MS.M.Ch. Cell.No.9843050822 (Oncology) drbkcmp@gmail.com	Professor & H.O.D of Surgical Oncology (Retired) D.No.32, West Avani Moola Street, Madurai.-1	Member Secretary
3. Dr.L.Santhanalakshmi, MD (Physiology) Cell No.9842593412 dr.l.santhanalakshmi@gmail.com.	Vice Principal, Prof. & H.O.D. Institute of Physiology Madurai Medical College	Member
4.Dr.K.Parameswari, MD(Pharmacology) Cell No.9994026056 drparameswari@yahoo.com.	Director of Pharmacology Madurai Medical College.	Member
5.Dr.S.Vadivel Murugan, MD., (Gen.Medicine) Cell No.9566543048 svadivelmurugan_2007@rediffmail.com.	Professor & H.O.D of Medicine Madurai Medical College	Member
6.Dr.A.Sankaramahalingam, MS., (Gen. Surgery) Cell.No.9443367312 chandrahospitalmdu@gmail.com	Professor & H.O.D. Surgery Madurai Medical College.	Member
7.Mrs.Mercy Immaculate Rubalatha, M.A., Med., Cell.No.9367792650 lathadevadoss86@gmail.com	50/5, Corporation Officer's Quarters, Gandhi Museum Road, Thamukam, Madurai-20.	Member
8.Thiru.Pala.Ramasamy, B.A.,B.L., Cell.No.9842165127 palaramasamy2011@gmail.com	Advocate, D.No.72,Palam Station Road, Sellur, Madurai-20.	Member
9.Thiru.P.K.M.Chelliah, B.A., Cell No.9894349599 pkmandco@gmail.com	Businessman, 21 Jawahar Street, Gandhi Nagar, Madurai-20.	Member

The following Project was approved by the Ethical Committee

Name of P.G.	Course	Name of the Project	Remarks
V.Vanitha Vanitha kumar 62@gmail.com	M.Sc (Nursing) 1st year Obstetrics and Gynecologiy, Madurai Medical College, Madurai.	**" A study to evaluate the effectiveness of music therapy on postnatal blue among primi postnatal mother in postnatal ward at GRH, Maudrai.**	**Approved**

Please note that the investigator should adhere the following: She/He should get a detailed informed consent from the patients/participants and maintain it Confidentially.

1. She/He should carry out the work without detrimental to regular activities as well as without extra expenditure to the institution or to Government.
2. She/He should inform the institution Ethical Committee, in case of any change of study procedure, site and investigation or guide.
3. She/He should not deviate the area of the work for which applied for Ethical clearance. She/He should inform the IEC immediately, in case of any adverse events or Serious adverse reactions.
4. She/He should abide to the rules and regulations of the institution.
5. She/He should complete the work within the specific period and if any Extension of time is required He/She should apply for permission again and do the work.
6. She/He should submit the summary of the work to the Ethical Committee on Completion of the work.
7. She/He should not claim any funds from the institution while doing the work or on completion.
8. She/He should understand that the members of IEC have the right to monitor the work with prior intimation.

Member Secretary
Ethical Committee

Chairman
Ethical Committee

13.11.14.

DEAN/Convenor
Madurai Medical College &
Govt. Rajaji Hospital, Madurai.

To
The above Applicant
-thro. Head of the Department concerned

APPENDIX-II

LETTER SEEKING PERMISSION FOR VALIDATION OF CONTENT AND TOOL

From

Mrs.Vanitha.V

M.sc(N)-II year

College of nursing,

Madurai medical college,

Madurai-20.

To

Mrs. C. Radha, M.Sc(N)
Asso. Professor
Karpaga Vinayaga College of Nursing
Pudukottai.

Through the proper channel,

Respected Madam,

Sub: Requesting opinion and suggestion for content validity of tool to "**A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI.**"

I am second year M.sc(Nursing) student of college of nursing, Madurai medical college, Madurai. In partial fulfillment of master degree in nursing, I have selected the above topic for the dissertation to submit to the Dr.MGR Medical University, Chennai. I request you to kindly validate the tool and give your expert opinion for secondary modification and also I would be very grateful if you could refine problem statement and objectives.

Thanking you,

Madurai

01-06-15

your's sincerely,

Vanitha.

(Vanitha.V)

APPENDIX III

CONTENT VALIDITY CERTIFICATES

Section B : standardized AM I BLUE Scale

Prepared By Mrs.Vanitha.v II year M.Sc(Nursing) student of Government Rajaji Hospital, Madurai who has undertaken the study field titled of **"A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."** has been validated by me.

SIGNATURE OF THE EXPERT

PROF. & HOD
DEPT. OF O&G
Madurai Medical College
Madurai

NAME: Dr. C. Shanthi M.D., D.G.O., FICOG

DESIGNATION:

DATE: 05.08.15

CERTIFICATE OF VALIDATION

This is to certify that the tool,

Section A : demographic data

Section B : standardized AM I BLUE Scale

Prepared By Mrs.Vanitha.v II year M.Sc(Nursing) student of Government Rajaji Hospital, Madurai who has undertaken the study field titled of **"A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."** has been validated by me.

SIGNATURE OF THE EXPERT

NAME: DR. K.S. CHITRA MD DGO DNB

DESIGNATION: Professor
Dept. of OG
Govt. Rajaji Hospital
Madurai.

DATE: 05/08/15

CERTIFICATE OF VALIDATION

This is to certify that the tool,

Section A : demographic data

Section B : standardized AM I BLUE Scale

Prepared By Mrs.Vanitha.v II year M.Sc(Nursing) student of Government Rajaji Hospital, Madurai who has undertaken the study field titled of **"A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."** has been validated by me.

SIGNATURE OF THE EXPERT

NAME: Ms. Radha. C

DESIGNATION: Associate Professor

DATE: 06.06.2015

CERTIFICATE OF VALIDATION

This is to certify that the tool,

Section A : demographic data

Section B : standardized AM I BLUE Scale

Prepared By Mrs.Vanitha.v II year M.Sc(Nursing) student of Government Rajaji Hospital, Madurai who has undertaken the study field titled of **"A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."** has been validated by me.

SIGNATURE OF THE EXPERT

NAME: Mrs. JAYASANKARI.S.

DESIGNATION: Asso Prof & HOD Dept of OBG Nsg.

DATE: 18/6/15

CERTIFICATE OF VALIDATION

This is to certify that the tool,

Section A : demographic data

Section B : standardized AM I BLUE Scale

Prepared By Mrs.Vanitha.v II year M.Sc(Nursing) student of Government Rajaji Hospital, Madurai who has undertaken the study field titled of **"A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."** has been validated by me.

SIGNATURE OF THE EXPERT

NAME: P.SHANTHI

DESIGNATION: Professor

DATE: 10/8/15

CERTIFICATE OF VALIDATION

This is to certify that the tool,

Section A : demographic data

Section B : standardized AM I BLUE Scale

Prepared By Mrs.Vanitha.v II year M.Sc(Nursing) student of Government Rajaji Hospital, Madurai who has undertaken the study field titled of **"A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."** has been validated by me.

SIGNATURE OF THE EXPERT

NAME: Dr. T. KUMANAN, M.D.(PSY).DPM
Reg. No. 42857
Professor of Psychiatry / Senior Civil Surgeon
Madurai Medical College / Govt. Rajaji Hospital
Madurai

DESIGNATION:

DATE: 15.9.2015

APPENDIX IV

INFORMED CONSENT FORM

ஒப்புதல் அறிக்கை

பெயர்: **நாள் :**

எனக்கு இந்த செவிலிய ஆய்வினை (பிரசவத்தின் போது ஏற்படும் ஹார்மோன் மாற்றத்தினால் சில மனமாற்றங்கள் வரும் என்பதை) பற்றிய முழு விபரம் விளக்கமாக எடுத்துரைக்கப்பட்டது. இந்த ஆய்வில் பங்கு கொள்வதில் இருக்கும் நன்மைகள் மற்றும் பின்விளைவுகள் பற்றி முழுமையாக புரிந்து கொண்டேன். இந்த ஆய்வில் தானாக முன் வந்து பங்கு பெறுகிறேன்.மேலும் எனக்கு இந்த ஆய்வில் இருந்து எந்த சமயத்திலும் விலகி கொள்ள முழு அனுமதி வழங்கப்பட்டுள்ளது.என்னுடைய விபரங்களை பார்வையிட்டு அதை ஆய்வில் பயன்ப்படுத்தி கொள்ள முழு அனுமதி அளிக்கிறேன்.என்னுடைய பெயர் மற்றும் அடையாளங்களை இரகசியமாக வைத்து கொள்ளப்படும் என்றும் எனக்கு உறுதியளிக்கப்பட்டுள்ளது.

இப்படிக்கு,

CONSENT FORM

Name:

Date:

I have been well explained about the Music theraphy and its importance. Here by agree to participate in this study if any complications arises the doctors, nurses and the management is not responsible for that. I have given full freedom to leave the study at anytime and I am assured by the researcher that my information will be confidential.

Signature

APPENDIX V

LETTER SEEKING PERMISSION TO CONDUCT THE PILOT STUDY

From

Mrs.V.Vanitha

M.Sc (N) – II year,

College of Nursing,

Madurai Medical College,

Madurai – 20.

To

The Professor and Head of the department,

Department of Obstetrics and Gynaecology,

Government Rajaji Hospital,

Madurai – 20.

Through proper channel,

Respected Madam,

Sub: Requesting permission to conduct pilot study in postnatal ward-Reg.

As per the curriculum recommended by the INC and the Tamil Nadu Dr. M.G.R Medical University, all the M.Sc (nursing) students are required to conduct a study for the partial fulfillment of the course.

I have selected a topic on **"A study to assess the effectiveness of music therapy on postnatal blues among primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai".** I would like to conduct the pilot study from 01.06.15 to 06.06.15 in postnatal ward.

So, kindly I request you to consider, and permit me to conduct the pilot study in postnatal ward.

Thanking You,

Madurai – 20,
26-05-2015

Yours Sincerely,
(Vanitha.V)

Forwarded
S. Rajangam
26/5/15
For Principal
COLLEGE OF NURSING
Madurai Medical College
Madurai-20.

28/5/15
PROF. & HOD
DEPT. OF O & G
Madurai Medical College
Madurai

APPENDIX VI

LETTER SEEKING PERMISSION TO CONDUCT THE STUDY

Permitted
11-9-14

From

Mrs.V.Vanitha,

1st year M.Sc (Nursing),

College Of Nursing,

Madurai Medical College,

Madurai – 20.

To

The Dean

Madurai Medical College

Madurai – 20.

Through the proper channel,

Respected Sir,

Sub: College of Nursing, Madurai Medical College, Madurai – M.sc(N)- 1st year, Requesting permission to conduct a study in postnatal ward -Regarding

As per the curriculum recommended by the INC and the Tamil Nadu Dr. M.G.R Medical University, all the M.Sc (nursing) students are required to conduct a study for the partial fulfillment of the course.

I have selected a study on "A study to assess the effectiveness of music therapy on postnatal blues among primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai" for my study. I would like to conduct the study in postnatal ward.

So, kindly I request you to consider, guide and allow me conduct the study.

Thanking You,

Madurai – 20,

11 -09-2014

Yours Sincerely,

(V.Vanitha)

Forwarded
S.P
11/9/14

From

Mrs.V.Vanitha,

1st year M.Sc (Nursing),

College Of Nursing,

Madurai Medical College,

Madurai – 20.

To

The Professor and Head Of The Department,

Department Of Obstetrics and Gynaecology,

Government Rajaji Hospital,

Madurai – 20.

Through proper channel,

Respected Sir,

SUB: Requesting permission to conduct a study in postnatal ward -Regarding

As per the curriculum recommended by the INC and the Tamil Nadu Dr. M.G.R Medical University, all the M.Sc (nursing) students are required to conduct a study for the partial fulfillment of the course.

I have selected a topic on "A study to assess the effectiveness of music therapy on postnatal blues among primi postnatal mothers in postnatal ward at Government Rajaji Hospital, Madurai" . I would like to conduct the study in postnatal ward.

So, kindly I request you to consider and permit me to conduct the study in Obstetrics and Gynaecology department.

Thanking You,

Madurai – 20,
03-07-2014

Yours Sincerely,

(V.Vanitha)

Forwarded for consideration.

Mrs. N. NAGARATHINAM, M.Sc., (N)
Lecturer in Pediatric Nursing
College of Nursing
Madurai Medical College
Madurai-625 020.

Permitted.

PROF. & HOD
DEPT. OF O & G
Madurai Medical College
Madurai

APPENDIX VII

SECTION-A

SOCIO DEMOGRAPHIC DATA

1. Age of the mother ☐

a) 18-22 yrs

b) 23-27 yrs

c) 28-32 yrs

2.Education status ☐

a) No formal education

b) Primary education

c) Higher secondary education

d) Graduate

3.Occupation ☐

a) Home maker

b) Daily wages

c) Private employee

d) Government employee

4.Income ☐

a) Rs. 3000-4000

b) Rs.4001-5000

c) Rs.5001-6000

d) Rs.>6000

5. Religion ☐

a) Hindu

b) Muslim

c) Christian

6. Type of family ☐

a) Nuclear family

b) Joint family

c) Extended family

d) Separated family

7. Duration after marriage ☐

a) 0-1 year

b) 2-5 years

8. Marrital relationship ☐

a) Satisfied

b) Unsatisfied

9. **food habits** ☐

a) Vegetarian

b) Non-vegetarian

PART - II

OBSTETRIC VARIABLES

10. Weeks of gestation ☐

a) <37 weeks

b) 37-38weeks

c) 39-40 weeks

11. Baby gender ☐

a) Male

b) Female

12. Stressful events during pregnancy ☐

a) Yes

b) No

13.Family Support system ☐

a) Husband

b) Relatives

14.Family history of depression ☐

a) Yes

b) No

15.Obstetric outcome ☐

a) Healthy baby

b) Preterm baby

c) Low birth weight

APPENDIX VII

AM I BLUE? QUESTIONNARIE

0-Not there at all 1-mild 2-moderate 3-severe	**0**	**1**	**2**	**3**
Anger				
Anxiety attacks periods of very strong fear				
Increased or decreased appetite				
Strong feeling that you need to get away				
Problems in relationship with the family member				
Crying spells				
Less interest in your personnel appearance				
Less motivation-less energy				
Depression				
Fatigue-feeling tired				
Fear of harming yourself or your body				
Loss of your sense of humor				
Nervousness, feeling tense				
Feelings of guilty				
Feelings of panic				
Feelings alone or lonely, without the support of others				
Feeling no love, or not enough love, for your baby				
Feeling forgetful, distracted, absentminded				
Frustration				
Hopelessness				
Insomnia				
Feeling irritable				
Loss of sexual desire				
Loss of self respect or confidence				
Feeling confused and uncertain				
Mood swings your moods and emotions change all the time				
Obsessive thoughts-ideas you can't stop from repeating in your mind.				
Frightening thoughts.				
Thoughts of suicide				
Feeling sad and unhappy.				

Scoring procedure

The tool consist of 30 items. The total score is 90 which were given by 0-No symptoms, score (1)-mild symptoms , score (2)-moderate symptoms, score(3)-severe symptoms.

Interpretation

0 - Normal

1-30: Mild Blues

This will probably pass but pay attention and needs

31-60: Moderate Blues

To need help from a close friend or family member, or advice from health care provider.

61-90: Severe Blues

Depressed need health care provider for check up and advice as soon as possible.

APPENDIX IX

பகுதி-அ
பிரிவு-1
தன்னிலை விபரக்குறிப்பு

1.தாயின் வயது வருடங்களில் ☐

அ.18-22 வயது

ஆ.23-27 வயது

இ.28-32 வயது

2.கல்வித்தகுதி ☐

அ. படிக்காதவர்

ஆ. உயர்நிலைக்கல்வி

இ. மேல்நிலைக்கல்வி

ஈ. பட்டப்படிப்பு

☐

3.வேலை

அ.குடும்பத்தலைவி

ஆ.கூலி வேலை

இ.தனியார் வேலை

ஈ.அரசாங்க வேலை

4.மாதவருமானம் ☐

அ.ரூ.3000 முதல் 4000 வரை

ஆ.ரூ.4001முதல் 5000 வரை

இ.ரூ.5001முதல் 6000 வரை

ஈ ரூ. >6000

5. மதம் ☐

அ.இந்து

ஆ.கிறிஸ்துவம்

இ.முஸ்லிம்

6.குடும்பவகை ☐

அ.தனிக்குடும்பம்

ஆ.கூட்டுக்குடும்பம்

இ.விரிவாக்கக்குடும்பம்

ஈ.பிரிந்தகுடும்பம்

7. திருமணத்திற்கு பின் கால அளவு ☐

அ. 0-1 வருடம்

ஆ. 2-5 வருடம்

8.திருமண உறவு

அ. திருப்திகரமான உறவு

ஆ. அதிருப்தி ☐

9.உணவு முறை

அ. சைவம்

ஆ. அசைவம்

பிரிவு-ஆ

மகப்பேறுகால விபரங்கள்

10. பிரசவகாலம் வாரங்களில் ☐

அ.< 37வாரங்கள்

ஆ .37--38 வாரங்கள்

ஈ.40 -க்கு மேல் வாரங்கள்

11. குழந்தையின் பாலினம் ☐

அ.ஆண்

ஆ.பெண் ☐

12. கர்ப்பக்காலத்தில் மனதை பாதிக்கும் நிகழ்வுகள் நடந்துள்ளதா?

அ. ஆம்

ஆ. இல்லை

13. குடும்ப ஆதரவு ☐

அ.கணவர்\

ஆ.உறவினர்கள்

14. குடும்பத்தில் யாரேனும் மனஅழுத்தத்தினால் ☐

பாதிக்கப்பட்டிருக்கிறார்களா?

அ. ஆம்

ஆ. இல்லை

15. மகப்பேறியல் விளைவு ☐

அ..நலமான குழந்தை

ஆ.குறை மாத குழந்தை

இ.எடைகுறைவான குழந்தை

APPENDIX X

பேறுகால ப்ளூஸ் கேள்வித்தாள்

வ. எண்	கூறுகள்	0	1	2	3
1.	கோபம்				
2.	கவலையுடன்கூடிய மிகவும் வலுவான பயம், மூச்சுதிணறல், அதிகமான இதயத்துடிப்பு				
3.	பசியின்மை/அதிகமானபசி, எடைஅதிகரிப்பு அல்லது எடை குறைதல்				
4.	வலுவான உணர்வுகளிடமிருந்து விலகிக்கொள்ளுதல் மற்றும் அதிக நேரம் செலவிடுதல்				
5.	உறவுமுறைகளில் பிரச்சினை(குடும்பஉறுப்பினர்கள் அல்லது நண்பர்கள்)				
6.	கட்டுப்படுத்த முடியாத அழுகை				
7.	தனிப்பட்டதோற்றத்தில் விருப்பம் இல்லாமை				
8.	குறைந்த உள்நோக்கம், இலக்கை அடைய விருப்பம் இல்லாமை				
9.	மன அழுத்தம்				
10.	சோர்வாக உணருதல்				
11.	உடலுக்குதீங்கு விளைவிக்கும் பயம்				
12.	நகைச்சுவை மேல் விருப்பம் இல்லாமை				
13.	பதட்டமாக உணருதல்				
14.	குற்றஉணர்வு				
15.	பீதிஉணர்வுகள்				
16.	தனிமையாக உணருதல், மற்றவர்கள் ஆதரவு இல்லாமை				
17.	குழந்தைக்கு அன்பு இல்லை அல்லது போதுமான அன்பு இல்லை என்ற உணர்வு				
18.	கவனம் இல்லாத உணர்வு மற்றும் கட்டாயபடுத்தும் உணர்வு				
19.	ஏமாற்றம்				
20.	நம்பிக்கையின்மை				
21.	தூக்கமின்மை				
22.	எரிச்சலான உணர்வு				
23.	உடலுறவில் விருப்பமின்மை				
24.	சுயமரியாதையில் நம்பிக்கையின்மை எதையும் சரியாக செய்யமுடியமை				
25.	உறுதியற்றதாக அல்லது குழப்பமாக உணருதல்				
26.	நிலையான எண்ணங்கள் இல்லாதிருத்தல்				
27.	துன்புறுத்தும் சிந்தனைகளை கட்டுப்படுத்தமுடியாமை				
28.	அச்சுறுத்தும் சிந்தனைகள்				
29.	தற்கொலை எண்ணங்கள்				
30.	வருத்தம் மற்றும் மகிழ்ச்சியற்ற உணர்வு				

மதிப்பெண் பட்டியல்:

எதுவுமில்லை-0, லேசான-1, அதிகமான-2, மிகஅதிகமான-3

<u>மதிப்பெண்</u>

0 = எதுவுமில்லை

0-30 = லேசான பாதிப்பு

31-60 = அதிகமான பாதிப்பு

61-90 = மிகஅதிகமானபாதிப்பு

மொத்தமதிப்பெண்= 90

APPENDIX XI

ENGLISH EDITING CERTIFICATE

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the dissertation by **VANITHA.V** II year M.Sc(N) student, College of nursing, Madurai medical college, Madurai, who has undertaken the study field on dissertation entitled **""A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."**Has been edited for English language appropriateness.

SIGNATURE:

NAME: SHANTHI. N

DESIGNATION: B.T. Asst.

INSTITUTION:

APPENDIX XII

TAMIL EDITING CERTIFICATE

CERTIFICATE OF TAMIL EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the dissertation by VANITHA.V II year M.Sc(N) student, College of nursing, Madurai medical college, Madurai, who has undertaken the study field on dissertation entitled **""A STUDY TO EVALUATE THE EFFECTIVENESS OF MUSIC THERAPY ON POSTPARTUM BLUES AMONG PRIMI POSTNATAL MOTHERS IN POSTNATAL WARD AT GOVT. RAJAJI HOSPITAL ,MADURAI."**Has been edited for Tamil language appropriateness.

SIGNATURE:

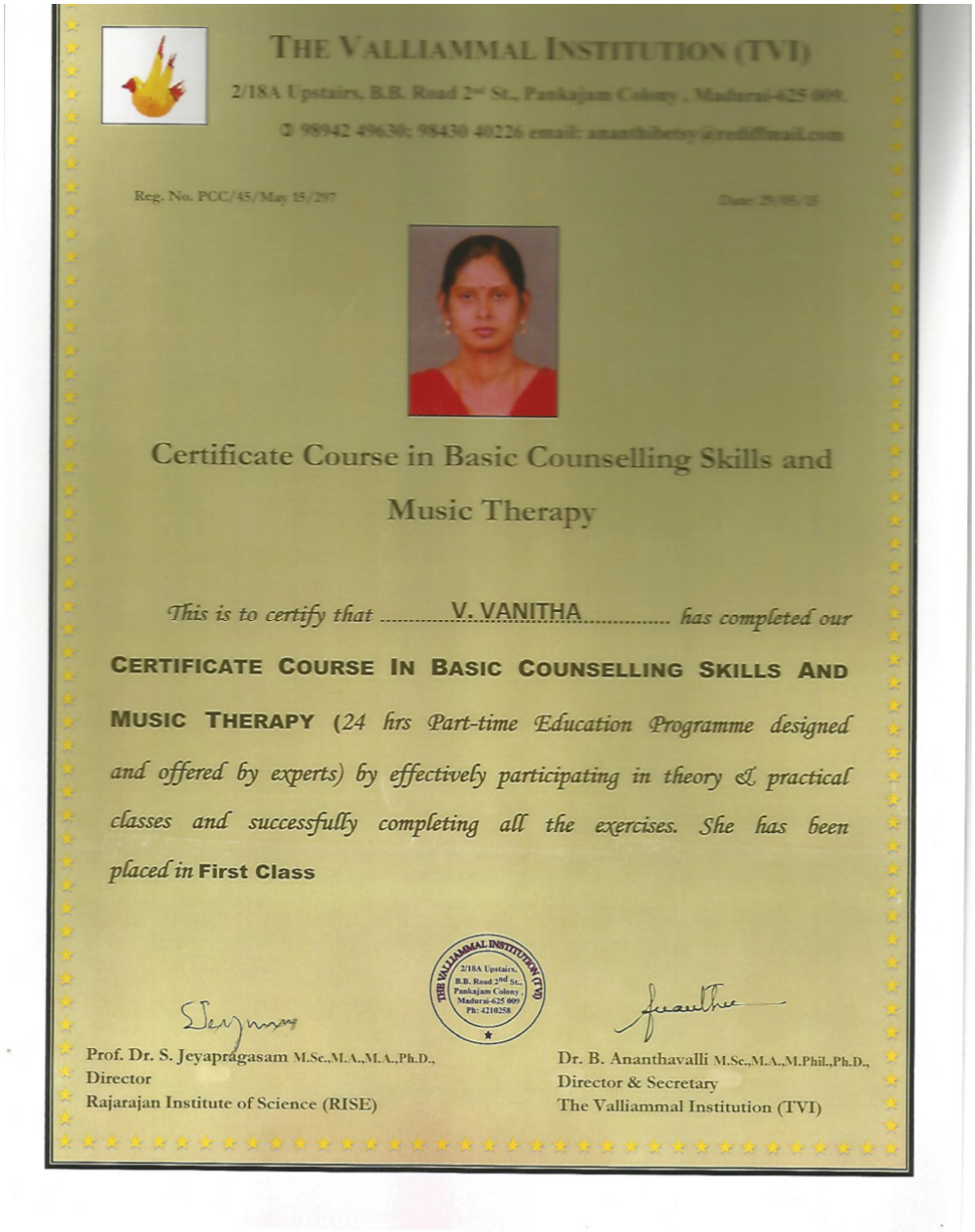
NAME: P. SATHIYABAMA
M.A., M.Ed., M.Phil

DESIGNATION: Head Mistress,

INSTITUTION: Panchayat Union Middle School,
Vadakkuvalaiyapatti,
Melur (Tk), Madurai-625 109.

APPNDIX XIII

TRINING CERTIFICATE FOR MUSIC THERAPY



THE VALLIAMMAL INSTITUTION (TVI)

2/18A Upstairs, B.B. Road 2nd St., Pankajam Colony , Madurai-625 009.

✆ 98942 49630; 98430 40226 email: ananthibetsy@rediffmail.com

Reg. No. PCC/45/May 15/297 Date: 29/05/15

Certificate Course in Basic Counselling Skills and Music Therapy

This is to certify that V. VANITHA *has completed our* **CERTIFICATE COURSE IN BASIC COUNSELLING SKILLS AND MUSIC THERAPY** *(24 hrs Part-time Education Programme designed and offered by experts) by effectively participating in theory & practical classes and successfully completing all the exercises. She has been placed in* **First Class**

THE VALLIAMMAL INSTITUTION (TVI) 2/18A Upstairs, B.B. Road 2nd St., Pankajam Colony, Madurai-625 009 Ph: 4210258

Prof. Dr. S. Jeyapragasam M.Sc.,M.A.,M.A.,Ph.D.,
Director
Rajarajan Institute of Science (RISE)

Dr. B. Ananthavalli M.Sc.,M.A.,M.Phil.,Ph.D.,
Director & Secretary
The Valliammal Institution (TVI)

APPENDIX-XIV

PHOTOGRAPHS